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Hearings. v. 18-19. 1962

1964

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

REGINA

SASK.

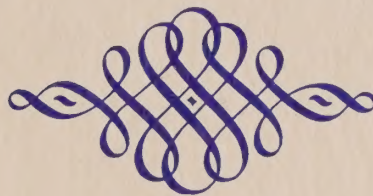
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January 23rd, 1962

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SASKATCHEWAN BRANCH

COLLEGE OF PHYSICIANS AND SURGEONS OF
SASKATCHEWAN CANADIAN MEDICAL ASSOCIATION
SASKATCHEWAN DIVISION

MISS GRACE STEWART
COMMISSION MEMBERS:

CHIEF DISTRICT JUDGE EMMETT H. HALL - Chairman
SASKATCHEWAN ASSOCIATION FOR RETARDED
CHILDREN
MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

VICTORIAN ORDER OF NURSES
SASKATCHEWAN DIVISION
PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN
THE SASKATCHEWAN REGISTERED NURSES' ASSOCIATION
DR. ARTHUR F. VAN WART

SASKATCHEWAN FARMERS' UNION
COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



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ROYAL COMMISSION ON HEALTH SERVICES

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held at Regina, Saskatchewan,
January 23rd, 1962

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SECRETARY:

MR. N. LAFRANCE

Proceedings of the hearing
held at Regina, Saskatchewan,
January 28th, 1962

CHAIRMAN - JUSTICE EMILY F. HALL

MISS ALICE GIBSON, P.M.

DR. DAVID M. BARTON

MR. M. WALLACE MONTGOMERY, O.C.

DR. C.L. STRATHAN

MR. ARTHUR E. VAN WART

PROSECUTION COUNSEL:

MEDICAL CONSULTANT:

DR. FREDERICK JOHNSON

DIRECTOR OF RESEARCH:



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Regina, Saskatchewan,
Tuesday,
January 23rd, 1962

---ON RESUMING AT NINE O'CLOCK A.M.

THE CHAIRMAN: We will come to order and proceed. Mr. Davies, are you in a position to give the figure on a percentage of population covered by the Hospitalization Act?

HON. MR. DAVIES: I think so, sir. I think one of our advisers here could answer that. It sticks in my mind, and I am guessing now, that it is something in the order of 96 percent or 97 percent, probably a little better than that. Our advisers can give you a more precise figure if you would not mind holding that question. On the basis of the census of Saskatchewan, 910,000 in 1960, there was a 98.9 percent coverage. The number of beneficiaries, if you are interested, was 899,648.

THE CHAIRMAN: Now, can you say of that number how many had the premium paid for them? I take it this figure includes those who paid the premium and those for whom the premium was paid?

HON. MR. DAVIES: I would think so, yes.

THE CHAIRMAN: Would that be in Mr. Nicholson's department?

HON. MR. DAVIES: It may be we would have some of that information. I think we would have the information of the ones our department paid directly but we do not have the figure on municipalities. Is that correct, Dr. Roth?

DR. ROTH: That is right.

THE CHAIRMAN: As distinct from the social welfare?

HON. MR. DAVIES: Yes, we do not have the municipalities figure.

Tuesday

We will come to order and proceed. Mr. Davies, are you in a position to give the figures on a percentage of population covered by the

Hospitalization Act?

MR. DAVIES: I think so, sir. I think one of our advisers here could answer that. It sticks in my mind and I am guessing now that it is something in the order of 85 percent or 87 percent, probably a little better than that. Our advisers can give you a more precise figure if you would not mind holding that question. On the basis of the census of Saskatchewan, 1910, 1920 and 1930, there was a 85.8 percent coverage. The number of beneficiaries, if you are interested, was 8,100,000.

THE CHAIRMAN: Now, can you say of that number how many had the premium paid for them? I said at this figure includes those who paid the premium and those for whom the premium was paid?

MR. DAVIES: I would think so, yes.

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MR. ROY: That is right.

THE CHAIRMAN: As distinct from the social

Welfare?

MR. DAVIES: Yes, we do not have the municipi-



1
2
3 THE CHAIRMAN: Can you give me the figure of
4 those paid for by the Department, by the Provincial
5 Government?

6 DR. ROTH: Again for 1960 there is 39,787.

7 THE CHAIRMAN: In round figures, 40,000.

8 DR. ROTH: That is correct, yes.

9 THE CHAIRMAN: And I would expect that there
10 would be a similar figure on the Medical Services Plan?

11 DR. ROTH: It may be less.

12 THE CHAIRMAN: Why would it be less?

13 DR. ROTH: Well, in the Hospital Insurance
14 Programme persons who are covered by the Provincial
15 Government are people who are on Old Age Security Pensions
16 and who get the supplementary allowance from the Province.
17 People who get the Old Age Pension, certain other groups,
18 Mothers' Allowance Group, blind people and so on, there
19 has not yet been a decision by the Medical Care Commission
20 as to how these groups would be covered. When I say
21 "less" I mean very few less, it will not be exactly the
22 same figures.

23 THE CHAIRMAN: It is going to change from day
24 to day, I suppose, but is there any reason to say that
25 those who cannot pay the \$48.00 a year will be able to
26 pay an additional \$24.00? If they cannot pay for hospi-
27 talization do you expect they will be able to pay for
28 medical services?

29 DR. ROTH: No, sir.

30 HON. MR. DAVIES: I think the figure would definite-
ly be indicative, Mr. Chairman.

THE CHAIRMAN: And then additional to that
are those for whom payment is made by municipalities?



Can you give us the figure of those paid for by the Department by the Provincial

THE CHAIRMAN: In round figures, \$0,100.
DR. ROTH: That is correct, yes.

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THE CHAIRMAN: It is going to change from day to day, I suppose, but is there any reason to say that those who cannot pay the \$48.00 a year will be able to pay an additional \$48.00 if they cannot pay for hospitalization do you expect they will be able to pay for medical services?

DR. ROTH: No, sir.

HON. MR. DAVIES: I think the figure would be definite. It is indicative, Mr. Chairman.

THE CHAIRMAN: And then additional to that are those for whom payment is made by municipalities?



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HON. MR. DAVIES: Yes, sir.

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THE CHAIRMAN: Are there municipalities that pay for all residents of the municipality regardless of the question of ability to pay?

DR. ROTH: Not to our knowledge, sir.

THE CHAIRMAN: That has not been developed?

DR. ROTH: No, sir.

THE CHAIRMAN: Now, in the matter of question of priority that was being discussed yesterday afternoon, in Saskatchewan the choice was made to proceed first with Physicians' Services?

HON. MR. DAVIES: Yes, we are intending to proceed in that order, that is the choice.

THE CHAIRMAN: That is the historic statement now. Is this putting it fairly, that that decision was a Governmental one? I mean, that was the Government's view of what should be the order of priority?

HON. MR. DAVIES: I think it would be certainly a Governmental decision, but I have indicated, on the advice of our advisers.

THE CHAIRMAN: Do you mean the Advisory Planning Committee?

HON. MR. DAVIES: Yes.

THE CHAIRMAN: That is really what concerns me --

HON. MR. DAVIES: I am trying to find the sections that might deal with this.

THE CHAIRMAN: I am going to refer to one or two here because -- I want to refer you to the



Order-in-Council No. 729 of 1960 and that is the Order-in-Council which set up the Thompson Committee and on page II in the Report, the majority report it says:

"The Minister further states that the Government of Saskatchewan believes the following principles to be consistent with the fundamentals of responsible Democratic Government:

(1) The Medical Care Insurance Plan should be administered by a public body responsible to the Legislature through the Minister of Health. The premium should be based on a pre-payment principle with a personal tax basis.

The Government accepts the principle that there be universal coverage exempting only those who are provided by services by some other public programme."

Then you go on. Then, of course, the terms of reference are contained later in an Order-in-Council which was intended to set out the Government's position prior to and in setting up the Thompson Committee, was it not?

HON. MR. DAVIES: Yes.

THE CHAIRMAN: And then when the Committee went to work -- it has not yet completed its work?

HON. MR. DAVIES: All reports are not yet in.

THE CHAIRMAN: Now, is it a fact that the reason the interim report was brought in in this way was at the request of Government?

HON. MR. DAVIES: Yes, the Government had



requested as early as possible a report.

THE CHAIRMAN: Page 143 of the Report contains this statement:

"This Report is directed to the Minister of Health."

HON. MR. DAVIES: You have the large volume and we have the printed volume and we are having difficulty following you.

THE CHAIRMAN: This is pretty close to the end of it, this is in the minority report. This is the paragraph that reads:

"Following receipt of your letter requesting elaboration of a plan for Physicians' Services only the Advisory Planning Committee of Medical Care on a majority vote directed this portion almost exclusively to the consideration of a universal plan programme of the type referred to in the Resolution."

The Resolution was, of course, that the Medical Care Plan should provide for universal coverage and require all Saskatchewan residents who are able to do so to pay premiums to finance the plan.

"The Plan shall not require residents or providers on the service to join or to avail themselves of the benefits of the Plan."

So the matter of the Resolution is not of consequence in the matter I am talking about for the moment. The Commission, I think, is concerned with the manner in which this interim report came about because unless we know the true situation it might be accepted that the idea of a plan for Physicians' Services only



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this statement:

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and therefore all Saskatchewan residents who are able to

do so are required to finance the plan.

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providers on the service to join or to avail them-

selves of the benefits of the plan."

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consequence in the matter I am talking about for the

moment. The Commission, I think, is concerned with the

manner in which this interim report came about because

unless we know the true situation it might be suggested

that the idea of a plan for Physiotherapy services only



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2
3 originated with the Thompson Committee and not with
4 Government.

5 HON. MR. DAVIES: I think this interim report
6 definitely convinced the Government in being able to pro-
7 vide us with this information so we could proceed with
8 the Legislation in the fall of 1961. I think you will
9 appreciate a fairly decent period of time had gone by
10 since the election in 1960.

11 THE CHAIRMAN: I am not concerned with the
12 political implications. In my present capacity I have
13 ceased weighing political consideration.

14 HON. MR. DAVIES: I am not mentioning this
15 because you think of it but only mentioning that follow-
16 ing this time the Medical Care Committee was able to
17 follow its recommendations following the election. I had
18 no intention of bringing politics into these proceedings.

19 THE CHAIRMAN: Would this be a fair request?
20 That the Committee be furnished with a copy of that let-
21 ter referred to in this paragraph?

22 HON. MR. DAVIES: I understand this was a
23 letter from the then Minister of Public Health to the
24 Thompson Committee so the letter itself, of course, was
25 to Dr. Thompson. We would have a copy in our files and
26 I see no reason why your Commission should not have a
27 copy of it.

28 THE CHAIRMAN: Very well. The plan which the
29 Saskatchewan Medical Care Insurance Act 1961 brings into
30 being contemplates the setting up of a commission to
administer its provisions and I understand that the

Government.

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THE CHAIRMAN: Very well. The plan which the

being contemplated the setting up of a commission to administer its provisions and I understand that the



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3 Commission, once it is in being, has to formulate regu-
4 lations and all that kind of thing. I understand that
5 one of these duties would be to arrive at the basis of
6 payment for physicians' services?

7 HON. MR. DAVIES: I think this would definite-
8 ly be one of its duties, making of the arrangements neces-
9 sary for the conduct of the programme.

10 THE CHAIRMAN: Section 49 of the Act says:
11 "Subject to the approval of the Lieutenant-
12 Governor in Council the Commission may make regulations:

13 (c) Prescribing the rates of payment to
14 be made under this Act to physicians and
15 other persons."

16 So that whatever arrangement may be made
17 between the Commissions and the physicians, I mean the
18 College of Physicians and Surgeons or some group acting
19 on behalf of the Physicians, still remains subject to the
20 approval of the Lieutenant-Governor-in-Council.

21 HON. MR. DAVIES: Yes, the regulations are
22 certainly subject to the final approval of the Lieutenant-
23 Governor-in-Council.

24 THE CHAIRMAN: There is final political
25 judgment on the arrangement?

26 HON. MR. DAVIES: I would rather put it that
27 there is a final control by the elected representatives
28 of the people.

29 THE CHAIRMAN: So the Commission is to that
30 extent an agency of the Lieutenant-Governor-in-Council,
that is, of the Cabinet?

HON. MR. DAVIES: We view it as an agency



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3 that certainly is timely as far as its regulations are
4 concerned within the purview of that control but we do
5 not regard the Commission as a day to day operation, as
6 a body that is subservient to the control of Government.

7 THE CHAIRMAN: That may be the very liberal
8 view of a liberally disposed Minister but the machinery
9 is there for the exercise of control by Cabinet of the
10 Commission by either approving or disapproving of the
11 regulations.

12 HON. MR. DAVIES: I think machinery is there.
13 May I say a word on this?

14 THE CHAIRMAN: Well, I am only concerned with
15 what the Legislation actually is. You see, the intention
16 must always be regarded separately from the planned word-
17 ing of the act.

18 HON. MR. DAVIES: I was going to say a word
19 about the principle that lies behind the reasoning rather
20 than the matter that you are speaking of here. I think
21 what you are suggesting, I suppose it is quite right, that
22 Governments can change, Ministers can change, good in-
23 tentions can change. I was not going to direct my remarks
24 to that but to the principle justifying this type of an
25 arrangement.

26 THE CHAIRMAN: You understand that there are
27 two ways in which the operation of a Commission such as
28 which has been set up can be worked out. One is under
29 direct control of Cabinet which operates from day to day
30 or hour to hour or making it responsible to the Legis-
lature itself, to the elected representatives of the
people and not subject to the day to day control of
Cabinet.



AG/je

HON. MR. DAVIES: Well, I would certainly dispute that this Commission is subject to the day to day control of the Cabinet. I would say that this body here is certainly a body that is within the purview of that control, but if this was an agency of the Department of Public Health, if it were operating as one of its branches, I would think you are correct.

THE CHAIRMAN: Well, let us just pick up -- The report, does it not report through the Deputy Minister, who is an ex-officio member of the Commission, to the Minister of Health. Has there been any machinery set up for a day to day report to the Minister?

HON. MR. DAVIES: With no vote I would say.

THE CHAIRMAN: Whether he has a vote or not, he is the Minister's representative on the Commission.

HON. MR. DAVIES: Certainly I would think that the Deputy Minister would confer and consult. This does not imply that there is going to be the overt discussion that is going to be unpleasant or undesirable.

THE CHAIRMAN: What is unpleasant or undesirable is a matter of opinion. What may be very unpleasant and undesirable to the physicians may be pleasant and desirable to the Minister.

HON. MR. DAVIES: I think that there would be regulations that should there be any main departure good and bad, remembering that the Government must finally take responsibility for what does take place because of the actions of the Medical Care Commission and what they do, that there must be some connection, some link, and it is thought that this Commission here will have a



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and it is thought that this Commission here will have a



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3 considerable authority and a considerable degree of in-
4 dependence, but within the framework of our system how can
5 we have an arrangement where you have a totally discon-
6 nected Commission that has no responsibility either to the
7 Government or to the Legislature?

8 THE CHAIRMAN: I am not suggesting that there
9 should be no responsibility to the Legislature. I am sug-
10 gesting that in the over-all picture in any recommendations
11 should we give consideration to the fact that control
12 should be invested in Legislature rather than in Cabinet?

13 HON. MR. DAVIES: Well, of course I am not
14 sure that the -- there may be a distinction here. It seems
15 to me in any event that the Legislature is there. Sessions
16 meet regularly every year. They discuss the reports that
17 come down from all the agencies of Government and I have
18 no doubt that there will be many discussions and many
19 criticisms by the opposition of any actions by the Com-
mission or the Government, so it seems to me that in
analysis that it comes out to the same end.

20 THE CHAIRMAN: Do you think so in terms of
21 the Auditor General of Canada, or haven't you got such an
22 official by legislation in Saskatchewan, who is responsible
to no one but the Legislature?

23 HON. MR. DAVIES: A Provincial Auditor?

24 THE CHAIRMAN: Yes?

25 HON. MR. DAVIES: Yes sir, we do have a
26 Provincial Auditor.

27 THE CHAIRMAN: In dealing with these recom-
28 mendations which the Commission may make subject to the
29 approval of the Lieutenant-Governor-in-Council, in sub-
30 section G, prescribing the terms and conditions under

Government or to the Legislature?

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should be no responsibility to the Legislature. I am sug-

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THE CHAIRMAN: Yes?

HON. MR. DAVIES: Yes sir, we do have a

THE CHAIRMAN: In dealing with these recom-

mendations which the Commission may make subject to the

approval of the Lieutenant-Governor in Council, in sub-

section 6, prescribing the terms and conditions under



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3 which physicians and other persons may provide insured
4 services to beneficiaries, so that there would appear to
5 be from the language of the Statute an idea of rather de-
6 tailed control of what physicians and other persons may
7 do, in terms of insured services to beneficiaries?

8 HON. MR. DAVIES: I would suggest, Mr. Chair-
9 man, that there are many agencies of Government now, whose
10 recommendations are approved by the Lieutenant-Governor-
11 in-Council, where those recommendations are never dis-
12 turbed by the Lieutenant-Governor-in-Council, and the
13 regulations are passed in toto, and I would think that
14 there is no reason to believe that there is this day to
15 day interference, as has been suggested. I am not saying
16 that you suggested it, Mr. Chairman.

17 THE CHAIRMAN: If I may carry the analogy to
18 the suggestion you made yesterday afternoon to the type
19 of control that you saw coming was of the same nature of
20 those which are in being insofar as hospitals are con-
21 cerned, and the operation of the hospitals under the
22 Hospital Plan?

23 HON. MR. DAVIES: I think I spoke of a
24 regionalization, Mr. Chairman.

25 THE CHAIRMAN: No, I think you mentioned,
26 if I remember correctly, but I will put it to you directly
27 now. Are the controls which are inherent in this system
28 of Cabinet approval of regulations under the Medical Care
29 Insurance Act any different from the controls that are in
30 effect insofar as the workings of the hospitals are
concerned?

HON. MR. DAVIES: There would be no dif-
ference in principle, Mr. Chairman.



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THE CHAIRMAN: So that you see you opened a topic yesterday afternoon in connection with drugs, and is this a correct summary of what you said? That there was a limit put on the amount that any hospital can spend on drugs in any given year?

HON. MR. DAVIES: Well, I am not sure whether, I think I had something to say about this, Mr. Chairman. I think Dr. Roth also had something to say about it, and since this is in the area of an expert opinion, I think I would ask him to answer that.

THE CHAIRMAN: Well, it is a matter of regulation as I understand it?

DR. ROTH: It is a matter of practise, sir, rather than specific regulation.

THE CHAIRMAN: Well, is it a fact that in the hospitals that there is a limit put on the amount that will be paid by the Plan to any given hospital for drugs in a given year?

DR. ROTH: There was, this is rather a complicated arrangement, but previously up until the hospital year 1961, which is a hospital running on a calendar year basis, rather than the usual fiscal year basis, that prior to that there was a limit which would be recognized for drug costs.

THE CHAIRMAN: What do you mean, recognized?

DR. ROTH: Recognized for payment. That is, when the hospital submits its budget, the Rate Board reviews this budget in detail, breaking down each item.

THE CHAIRMAN: That is in advance?

DR. ROTH: Yes, on the basis of the budget that the hospital submits.



is this a correct summary of what you said? That there was a limit put on the amount that any hospital can spend on drugs in any given year?

HON. MR. DAVIES: Well, I am not sure whether I think I had something to say about this, Mr. Chairman. I think Dr. Roth also had something to say about it, and since this is in the area of an expert opinion, I think I would ask him to answer that.

THE CHAIRMAN: Well, it is a matter of regulation as I understand it?

DR. ROTH: It is a matter of practice, and rather than specific regulation.

THE CHAIRMAN: Well, is it a fact that in the hospitals that there is a limit put on the amount that will be paid by the plan to any given hospital for drugs in any given year?

DR. ROTH: There was, this is rather a complicated arrangement, but previously up until the hospital year 1961, which is a hospital running on a calendar year basis, rather than the usual fiscal year basis, that prior to that there was a limit which would be recognized for drug costs.

THE CHAIRMAN: What do you mean, recognized? DR. ROTH: Recognized for payment. That is, when the hospital submits its budget, the rate board reviews this budget in detail, breaking down each item.

THE CHAIRMAN: That is in advance? DR. ROTH: Yes, on the basis of the budget that the hospital submits.



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3 THE CHAIRMAN: And the hospital projects its
4 drug costs for the next calendar year?

5 DR. ROTH: That is right, sir.

6 THE CHAIRMAN: Yes.

7 DR. ROTH: And there was a limit which would
8 be recognized as the drug component what amount -- that is
9 per patient per day -- of the amount which we would pay
10 to hospitals. We would pay net cost covering the drugs
11 and medical and surgical supplies. Now, in this Province,
12 as I think the members of the Commission are aware, there
13 are certain drugs which are non-benefit drugs, so that
14 therefore we dealt with the net cost, rather than the
15 gross cost.

16 THE CHAIRMAN: Yes, and you excluded some
17 drugs altogether?

18 DR. ROTH: That were non-benefit, that is
19 right sir.

20 COMMISSIONER McCUTCHEON: Does that mean non-
21 beneficial, or that you don't choose to pay for them?

22 DR. ROTH: We don't choose to pay for them.
23 Now, in the last two years this has changed to some ex-
24 tent in that the arrangement that has been entered into
25 with hospitals for 1961, and again for 1962, is that
26 hospitals now, their budget has on the over-all been al-
27 lowed to increase a certain percentage amount.

28 THE CHAIRMAN: 3 percent, is it not?

29 DR. ROTH: That is right. This is for 1962
30 over the 1961 budget, and similarly about 2 3/4 percent
to 3 percent in 1961 over the 1960 budget.

Now, the Rate Board is not concerned at this
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3 is now expected to manoeuvre within this global sum of
4 money allotted to it.

5 THE CHAIRMAN: Let us examine the manoeuvre-
6 ability of the hospital in this matter of drugs. As I
7 understand it, drugs in the hospital, that is prescription
8 drugs?

9 DR. ROTH: Yes.

10 THE CHAIRMAN: Whether within or without the
11 hospital, or because some doctor has prescribed them?

12 DR. ROTH: That is correct, although in this
13 same category of course are the medical and surgical supplies
14 which have, there are some controls the hospital can ex-
15 ercise on the use of this material.

16 THE CHAIRMAN: But so far as drugs, let us
17 stay with drugs for the moment. The hospital is power-
18 less in this regard, because the amount of drugs that are
19 going to be used in any calendar year are determined by
20 the doctors who issue the prescriptions, are they not?

21 DR. ROTH: Well, I don't think the hospital is
22 necessarily powerless. If I may quibble with your word-
23 ing in that, they may influence their medical staff.

24 THE CHAIRMAN: That is what I mean. That you
25 expect that there is some expectation that the hospital
26 is going to ride herd on the doctors in the matter of
27 prescription?

28 DR. ROTH: No, I think the hospitals expect
29 doctors to ride herd on doctors.

30 THE CHAIRMAN: Well, whether it is doctors
riding herd on doctors, it is a matter of hospital ad-
ministration, attempting in some way to control the
volume of prescription drugs prescribed in a given year?

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THE CHAIRMAN: Let us examine the manuscript.

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DR. ROTH: Not necessarily volume, sir, it may be kind.

THE CHAIRMAN: Kind, that would involve the quality?

DR. ROTH: This is debatable as well.

THE CHAIRMAN: Well now, whose judgment would be taken, the doctors' or the hospital administration's?

DR. ROTH: The judgment of the hospitals, preferably the hospitals collectively, or not the hospitals, the doctors collectively on the medical staff. In fact, many hospitals now have formularies where they are able to decide on one type of drug within a class. Now, there are great variations in price.

THE CHAIRMAN: Within the class?

DR. ROTH: Yes, as you will recognize.

THE CHAIRMAN: Now, that is drugs, and when the Rate Board, and the Rate Board is what? Is it set up by statute, or is it a creation of the Department?

DR. ROTH: It is an administrative creation of the Department.

THE CHAIRMAN: And the Rate Board is the Board which finally determines what the budget will be allowed at?

DR. ROTH: Yes, sir.

THE CHAIRMAN: Now, in that is there a limitation put on that of the amount of money that can be spent by hospitals on nurses in a calendar year, nursing?

DR. ROTH: In a general way, yes.

THE CHAIRMAN: What is the ratio? I have heard it as 1 1/2 nurses to something or another?



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4 hospitals will staff their hospitals in order to provide
5 3.4 hours of nursing care per patient per day.

6 THE CHAIRMAN: And that of course is done in
7 advance?

8 DR. ROTH: That is correct.

9 THE CHAIRMAN: Now, when we come to 1961, the
10 Rate Board I take it as a result of Departmental policy,
11 issued instructions that increases in costs would be
12 limited to 3 percent over the previous budget?

13 DR. ROTH: Right, sir.

14 THE CHAIRMAN: And did that take into account
15 the fact that there might be wage increases in the
16 period?

17 DR. ROTH: Yes, sir.

18 THE CHAIRMAN: Or was there any type of wage
19 freeze involved in the application of this 3 percent?

20 DR. ROTH: No, sir.

21 THE CHAIRMAN: So that if a hospital had to
22 increase its wages, and by reason of other things ex-
23 ceeded its budget, where would the deficit come from?

24 DR. ROTH: Well, we are premising that they
25 have a deficit.

26 THE CHAIRMAN: Provided they have a deficit?

27 DR. ROTH: This would be their responsibility.

28 THE CHAIRMAN: And there from the municipal
29 standpoint is the municipality?

30 DR. ROTH: That is right.

THE CHAIRMAN: Which should mean that the
municipality would get the deficit from the taxpayers of



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THE CHAIRMAN: Which should mean that the



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the municipality?

DR. ROTH: Yes.

THE CHAIRMAN: Or, if it is a private hospital, they have got to dig down in their own private resources?

DR. ROTH: Yes.

THE CHAIRMAN: And that is the form of over-all control that is exercised over all hospitals in the Province? I am talking now of -- except the Government, of the Government hospitals?

DR. ROTH: Yes, sir.

THE CHAIRMAN: What is the policy of the Rate Board in respect to acknowledging responsibility for as an operating cost of special nursing when required, when required by the physician?

DR. ROTH: The policy of the Rate Board is that the hospital is expected to provide necessary nursing care as is required under our agreement with the Federal Government under the Hospital Insurance Act. We believe that necessary nursing care includes in some instances special nurses, devoting their full time, or almost their full time, to one patient. Special nursing for companionship, or if it is not necessary, it is the responsibility of the patient.

THE CHAIRMAN: For the social prestige of having a special nurse, yes. I am talking about where the nurse is ordered by the attending physician. May a hospital, is a hospital expected to draw on its existing personnel to provide that special nursing that may be ordered, or may it go out and employ a nurse in



CHAIRMAN: Or, if it is a private hos-

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of the Government hospitals?

DR. ROTH: Yes, sir.

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3 the open field?

4 DR. ROTH: They may arrange this in any way
5 they see fit. We don't interfere with this aspect of
6 hospitals at all.

7 THE CHAIRMAN: And if a situation arises
8 where that is of some frequent occurrence, it will add
9 substantially to the hospital's budget for nursing ser-
vice in a given year, will it not?

10 DR. ROTH: Well, we believe, sir, that using
11 this amount of 3.4 hours of nursing care per patient per
12 day, and having in mind the characteristics of the people
13 in hospitals in Saskatchewan, that this does allow hospi-
tals to make sufficient flexibility to make --

14 THE CHAIRMAN: This figure 3.4 is an arbitrary
15 figure, is it not?

16 DR. ROTH: Yes, sir.

17 THE CHAIRMAN: So the controls that are ex-
18 ercised over hospitals are in part built on this, and a
19 number of other arbitrary assumptions?

20 DR. ROTH: Well, arbitrary in the sense that
21 they are specific figures. These are based on experience.

22 THE CHAIRMAN: Well, and whether they are
23 based, and it is just the same as saying in the meal
24 that they used to talk about in the old Army days, 50/50.
One horse, one rabbit?

25 HON. MR. DAVIES: The difference here, Mr.
26 Chairman, is that there is a discussion between the
27 hospitals and the Rate Board before this is set.

28 THE CHAIRMAN: Yes, Mr. Minister. Perhaps
29 Dr. Roth will see that I have participated in a number
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4 of them. Are you aware, Mr. Minister, that there are
5 hospitals who are still discussing their 1956 and 1957
6 budgets with the Rate Board?

7 HON. MR. DAVIES: There may be, Mr. Chairman.
8 I think that on the whole the practice has been found to
9 be satisfactory.

10 THE CHAIRMAN: That is from the Rate Board's
11 standpoint, on the hospital?

12 HON. MR. DAVIES: I think from the hospitals',
13 from the standpoint of the Hospital Association. I have
14 a letter on file that I could show you from the Hospital
15 Association last year, conceding that the arrangements
16 made were satisfactory under the situation that the
17 Province found itself economically during the last year.

/RY/je 18 THE CHAIRMAN: The implication of that, Mr.
19 Minister, is this, is it not: that the operation at the
20 hospital by Government direction is to be subject to the
21 Government's judgment of the economic condition of the
22 day?

23 HON. MR. DAVIES: Someone has to make decisions,
24 Mr. Chairman, and somewhere along the line after consul-
25 tation this hard decision has to be made.

26 THE CHAIRMAN: But the Government makes it
27 and not the operators of the hospital?

28 HON. MR. DAVIES: In this case the Government
29 has to take the responsibility for it, yes.

30 THE CHAIRMAN: And you expect the same thing
would apply when we come to the payment of physicians'
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HON. MR. DAVIES: Yes; I think in the final



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3 analysis the agency of Government or Government itself
4 will have to make these decisions, and I think in the
5 long haul rather than finding these expenditures are
6 curtailed that they will rise by reason of giving better
7 medical care as time goes on.

8 THE CHAIRMAN: Is depreciation on the physical
9 plant recognized as an operating charge in the Province
10 of Saskatchewan for which the hospital is compensated by
11 the Rate Board?

12 DR. ROTH: No, sir; depreciation is no longer.
13 It was at one time recognized, but it is no longer
14 recognized.

15 THE CHAIRMAN: What about the 30 percent
16 contribution which the local community, whether it is a
17 municipality or a private organization, is required to
18 produce: is depreciation recognized on it now?

19 DR. ROTH: No, sir. That is regarded as their
20 responsibility.

21 THE CHAIRMAN: Is there any provision made
22 for the recouping to the hospital of that 30 percent
23 capital contribution?

24 DR. ROTH: Not directly, sir. I take it you
25 are referring to new construction?

26 THE CHAIRMAN: Yes.

27 DR. ROTH: And you are aware of the arrange-
28 ment for re-payment of past capital indebtedness?

29 THE CHAIRMAN: Well, past capital: it seems
30 some hospitals have been required to refinance at much
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THE CHAIRMAN: Well, past capital: it seems some hospitals have been required to reimburse at much higher rates under this new plan you referred to, were they not?



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3 DR. ROTH: Yes, sir; the basis of this is that
4 the Government depreciation was discontinued and the new
5 formula was applied in September 1960; the Government
6 agreed to repay the annual installments that hospitals
7 had facing them for past capital indebtedness. Some
8 hospitals had large debts which were due in a lump sum.
9 I think it has been necessary for this to be re-negotiated
10 by the hospital, as would presumably have been necessary
11 under any circumstances.

12 THE CHAIRMAN: But at an increase of 2, 2 1/2,
13 almost 3 percent in some cases, in the interest charges?

14 DR. ROTH: This may be true, although they
15 would -- this is one area in which we have no knowledge
16 of what arrangements these hospitals that had a large
17 debt coming due in a lump sum at some time after September
18 1st, 1960 -- how they proposed to pay this. They may
19 have had a fund set up. We would not know about this.
20 They may have had to refinance it. On the 30 percent --

21 THE CHAIRMAN: What about this interest which
22 such a hospital has to pay on its refinanced debt? Is
23 it recognized as an operating cost?

24 DR. ROTH: No, sir.

25 THE CHAIRMAN: Whose decision was that?

26 DR. ROTH: Whose decision was ... ?

27 THE CHAIRMAN: Not to recognize interest as
28 an operating charge?

29 DR. ROTH: That was a decision of the
30 Government.

THE CHAIRMAN: That is all, thank you.

HON. MR. DAVIES: If I may add one point,



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3 Mr. Chairman: the number of hospitals that they had to
4 refinance in a manner which you speak of apparently is
5 restricted to around eight or ten. This again, we admit,
6 is a crude estimate, but eight or ten of these hospitals
7 have had a large lump sum which they have to refinance,
8 which in itself is a rather peculiar financial arrange-
9 ment, but there are not the majority of hospitals in that
position.

10 THE CHAIRMAN: That may be true. I don't --

11 HON. MR. DAVIES: There are some.

12 THE CHAIRMAN: But to any one hospital to
13 which the situation applies of having to pay 5 1/2 or
14 6 percent on a large capital debt, that is a very seri-
15 ous situation. I mean, it must be so recognized in any
budget, I suppose?

16 HON MR. DAVIES: Yes. I call to mind one
17 hospital, not to mention its name, with a lump sum pay-
18 ment coming due this year, and a large part of the debt
19 that was originally contracted falls due as of 1962.
20 Unlike the usual arrangement, where at the end of a 10-
21 year or 15-year period the balance is very small, the
22 balance here was quite large, and in this type of situ-
23 ation, even with the old depreciation policy, the hospi-
tal would be in some difficulty.

24 COMMISSIONER McCUTCHEON: Following on this
25 discussion that has taken place, Mr. Davies, would you
26 agree that the people of the Province of Saskatchewan
27 are paying more for their hospitalization care than would
28 appear by a simple reading of the Act, which provides
29 for the payment of premiums, and so on?
30



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THE CHAIRMAN: That may be true. I don't --

THE CHAIRMAN: But to any one hospital to
which the situation applies of having to pay a 10 per
cent on a large capital debt, that is a very seri-
ous situation. I mean, it must be so recognized in any
budget, I suppose?

HON. MR. DAVIES: Yes. I call to mind one
hospital, not to mention its name, with a 10 per cent
debt coming due this year, and a large part of the debt
that was originally contracted falls due as of 1952.
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are paying more for their hospitalization care than would
appear by a simple reading of the Act, which provides
for the payment of premiums, and so on?



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3 HON. MR. DAVIES: Yes, I think they are paying
4 more. I don't think they are paying significantly more.

5 COMMISSIONER McCUTCHEON: Well, that is an
6 adjective.

7 HON. MR. DAVIES: It is an important one in
8 this context, Mr. McCutcheon.

9 COMMISSIONER McCUTCHEON: Well, Mr. Minister,
10 as I understand the Act -- and I am referring now to the
11 Medical Care Insurance Act -- Section 26: you specify a
12 list of services. Those are insured services, and those
13 are the only services for which the plan is responsible
14 for payment?

15 HON. MR. DAVIES: Yes; only the Act can set
16 forward what the Commission can cover.

17 COMMISSIONER McCUTCHEON: If you refer in my
18 document to page 70 of the Thompson Report you will find
19 a recommendation: "The Committee recommends that insured
20 persons should be entitled to have payment made on their
21 behalf for the following benefits unless excluded under
22 Section E below."

23 HON. MR. DAVIES: What is the heading there?

24 COMMISSIONER McCUTCHEON: "Benefits to be
25 provided to insured persons."

26 Now, this is merely for information:
27 reading and comparing the provision of Section 26 of the
28 Act with the recommendation A(1), the statute follows
29 almost exactly -- there are one or two minor differences
30 -- the wording of the recommendation of the Thompson
Committee, except the Sub-section (h) of the Thompson
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HON. MR. DAVIES: Yes; only the Act can set

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COMMISSIONER McCUTCHEON: If you refer in a document to page 72 of the Thompson Report you will find a recommendation. The Committee recommends that insured persons should be entitled to have payment made on their behalf for the following benefits unless excluded under Section 2 below."

HON. MR. DAVIES: What is the heading there?

COMMISSIONER McCUTCHEON: "Benefits to be

provided to insured persons."

Now, this is merely for information.

reading and comparing the provision of Section 16 of the Act with the recommendation A(1), the statute follows almost exactly -- there are one or two minor differences -- the wording of the recommendation of the Thompson Committee, except the Sub-section (b) of the Thompson Committee's recommendation is omitted. That reads:



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3 "Psychiatric treatment and provided by a
4 specialist in private practice in psychiatry." Does that
5 men that psychiatrists' services are not an insured
6 service?

7 HON. MR. DAVIES: My advice is that psychia-
8 tric service is included as a medical service.

9 COMMISSIONER McCUTCHEON: I see. That is
10 the Department's interpretation?

11 HON. MR. DAVIES: Yes.

12 COMMISSIONER McCUTCHEON: There is no other
13 significance, then, in omitting Section (h) which the
14 Thompson Committee put in?

15 HON. MR. DAVIES: I am advised it was con-
16 sidered to be a medical service as under 1(a) of the
17 report.

18 COMMISSIONER McCUTCHEON: That is the position
19 the Commission presumably will take?

20 HON. MR. DAVIES: Yes, I would think so.

21 COMMISSIONER McCUTCHEON: I refer you to
22 Section 31 of the Act, Mr. Davies: the only services
23 -- going back first to Section 2, sub-section (6), where
24 insured services are defined; and insured services means
25 the services mentioned in Section 26, to which we were
26 just referring, and they are not excluded by Section 27.
27 I then refer you to Section 31 which says when the Act
28 comes into force wherever under any trade union collective
29 bargaining agreement or under any terms or condition of
30 employment the employer contributes in any manner towards
the cost of health services in respect of his employees
or their dependents, then after a date fixed by the



"Psychiatric treatment and provided by a
specialist in private practice in psychiatry." Does the
men that psychiatrists' services are not an insured
services?

trio service included as a medical service.
COMMISSIONER McCUTCHEON: I see. That is

the Department's interpretation?
HON. MR. DAVIES: Yes.

COMMISSIONER McCUTCHEON: There is no other
significance, then, in omitting Section (f) which the
Thompson Committee put in?

HON. MR. DAVIES: I am advised it was con-
sidered to be a medical service as under 1(a) of the
report.

COMMISSIONER McCUTCHEON: That is the point
the Commission presumably will take?

HON. MR. DAVIES: Yes, I would think so.
COMMISSIONER McCUTCHEON: I refer you to

Section 31 of the Act, Mr. Davies; the only services
-- going back first to Section 3, sub-section (b), where
insured services are defined; and insured services means
the services mentioned in Section 28, to which we were
just referring, and they are not excluded by Section 27.
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3 Lieutenant-Governor-in-Council he shall pay to each em-
4 ployee the amount which he has heretofore been contri-
5 buting for health services. What is the differences be-
6 tween "health services" and "insured services"?

7 HON. MR. DAVIES: I would say it would be
8 all the services that the employer had covered at that
9 time and for which he was paying in whole or in part:
10 hospital services, medical services. I think it would
11 probably cover the range of most services offered by em-
12 ployers.

13 COMMISSIONER McCUTCHEON: In other words,
14 does that mean when this Act comes into force that you
15 are depriving employees of services which they have here-
16 tofore received, paid by their employer, and which will
17 not be covered under this Act?

18 HON. MR. DAVIES: As I understand the
19 Section, it provides the employer shall pay over to the
20 employee the sum he contributed towards these health
21 services in one way or another. It may be 50 percent or
22 75 percent or 100 percent.

23 COMMISSIONER McCUTCHEON: Let me see what
24 that means: supposing my employees are covered for home
25 nursing services, as some group plans do provide. Is it
26 going to be very satisfactory for the employee if I add
27 to his wages one dollar a month, but his group is through
28 and he certainly cannot provide himself with that type
29 of service on any individual contract at anything like
30 that cost. Why is that section there?

HON. MR. DAVIES: If there is any other
service that is not envisaged by the Act he will still



...for health services.

...between "health services" and "medical services."

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that cost. Why is that section there?

HON. MR. DAVIES: If there is any other



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3 have the ability to negotiate with his employer. I don't
4 think we are thinking of any other services here except
5 services provided by medical care and hospitalization.

6 COMMISSIONER McCUTCHEON: But why do you say
7 health services -- the only place in the Act that you use
8 that term?

9 HON. MR. DAVIES: I can only say I am sure
10 the intention was that if an employer had been contributing
11 to a plan involving health services, which I suggest to
12 you in the main covers hospitalization and medical care,
13 that he would make -- the contribution he had made to
14 those plans would be paid to the employee in the manner
described by this Section.

15 COMMISSIONER McCUTCHEON: In the main those
16 such plans may cover hospitalization and medical care,
17 but many of them cover other health services.

18 HON. MR. DAVIES: What ones are you thinking
19 of?

20 COMMISSIONER McCUTCHEON: Home nursing is the
21 one I mentioned.

22 HON. MR. DAVIES: Are there any plans covering
23 home nursing?

24 COMMISSIONER McCUTCHEON: Certainly: group
25 plans -- commercial plans.

26 HON. MR. DAVIES: Well, I don't know of any
27 plan in the Province at the time this was discussed --
28 the Government knew of no home nursing plans that were
29 covered by this type of arrangement. We are not dis-
30 puting the fact there may be some of these, but we don't
know of these in this Province.



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3 COMMISSIONER McCUTCHEON: You are suggesting
4 there are no plans in the Province...

5 HON. MR. DAVIES: Oh, no.

6 COMMISSIONER McCUTCHEON: ...that cover any-
7 thing other than care provided under your Hospital Act
8 and under your Medical Care Act?

9 HON. MR. DAVIES: No. There would be --
10 these plans may cover to some extent a drug benefit.

11 COMMISSIONER McCUTCHEON: So from here out
12 the employer is bound to pay the full amount he was contri-
13 buting to his employees and presumably he drops the group
14 policy and the drug benefit disappears?

15 HON. MR. DAVIES: I am afraid sir, I can't
16 answer that question. I have to think of a specific in-
17 stance before I can give a specific answer, but it does
18 seem to me that almost every one of these arrangements
19 has an amenable negotiation. What was intended here was
20 that the employee should recover the amount paid to him by
21 the employer so that this would not be lost to him in the
22 process of getting public medical care.

23 COMMISSIONER McCUTCHEON: Of course, he will
24 now have to pay income tax on it.

25 HON. MR. DAVIES: This may be, sir; I am not
26 quite sure.

27 COMMISSIONER McCUTCHEON: Let me ask one
28 more question: do you contemplate this section applying
29 to employees of the Government of Canada resident in
30 Saskatchewan?

31 HON. MR. DAVIES: I don't think we have any
32 authority to apply this clause to the employees of the



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3 Government of Canada.

4 THE CHAIRMAN: I was wondering if I was
5 going to get an increase of \$5.00 a month.

6 HON. MR. DAVIES: The employees of the
7 Government of Canada, Mr. Chairman, we know from their
8 application to us, are interested in seeing this type of
9 extra benefit provided for them in Saskatchewan.

10 COMMISSIONER McCUTCHEON: What do you mean
11 by extra benefit?

12 HON. MR. DAVIES: They have a plan now that
13 apparently gives them some fairly good coverage in at
14 least one respect, if one of the alternatives is accepted.
15 I would not like here to try and describe the plan, but
16 they would like to come under the Saskatchewan plan, and
17 they would like to have the Government of Canada donate
18 to the plan on behalf of the employee a sum that was
19 equal to the contribution made before.

20 THE CHAIRMAN: That would be additional to
21 any -- taking your own figures -- 60 percent contribution
22 the Government would make to the operation of the plan as
23 a whole?

24 HON. MR. DAVIES: As well.

25 THE CHAIRMAN: Is that what you -- --

26 HON. MR. DAVIES: This would be if this
27 took place, but of course this is not the situation now.
28 The situation now is that the Federal Government employee
29 will be paying something in sales tax and something also
30 in income tax. It is better for him, in his opinion --
at least in the opinion of the officials that represent
his association -- to come to some arrangement where he

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4 can be covered for medical care in Saskatchewan and that
5 the Government of Canada pay over an amount that is similar
6 or the same to what is paid now by the Government of Canada
7 to the present private plans.

8 COMMISSIONER McCUTCHEON: Mr. Minister, the
9 Commission under the Medical Care Act has now been estab-
10 lished and set up?

11 HON. MR. DAVIES: Yes.

12 COMMISSIONER McCUTCHEON: When do you expect
13 regulations to go forward?

14 HON. MR. DAVIES: I expect regulations to go
15 forward as soon as the Commission has come to the position
16 where it can give us these regulations. I can't tell you
17 exactly. This is the job of the Commission. I would have
18 no intention of asking them to proceed any faster than
19 they can proceed under the circumstances.

20 THE CHAIRMAN: I suppose we will have access
21 to them once they are available, because it is a public
22 document?

23 HON. MR. DAVIES: Yes.

24 COMMISSIONER McCUTCHEON: I just want to
25 follow up one point you discussed with the Chairman:
26 when those regulations come forward from the Commission
27 they will be approved either with or without amendment
28 by the Lieutenant-Governor-in-Council?

29 HON. MR. DAVIES: Yes, they are subject to
30 the approval of the Lieutenant-Governor-in-Council.

COMMISSIONER McCUTCHEON: And they don't be-
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HON. MR. DAVIES: That is correct.

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COMMISSIONER McCUTCHEON: They cannot subsequently be amended without the approval of the Lieutenant-Governor-in-Council?

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HON. MR. DAVIES: No, I would say that amendments too would come under the same process.

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COMMISSIONER McCUTCHEON: Yes, because it is a regulation?

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HON. MR. DAVIES: Yes.

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COMMISSIONER McCUTCHEON: So once those rates are established, whatever they may be, they cannot subsequently be changed without the approval of the Lieutenant-Governor-in-Council?

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HON. MR. DAVIES: I would say that initially they cannot be changed without discussion of the first parties, the Commission and those rendering the benefit.

COMMISSIONER McCUTCHEON: The final change must be with the consent of the Lieutenant-Governor-in-Council?

HON. MR. DAVIES: It is a fact it will have



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COMMISSIONER McCUTCHEN: Yes, because it is

a regulation?

HON. MR. DAVIES: Yes.

There will, among other things you mentioned in your

brief -- you mentioned a number of times yesterday you

didn't attempt detailed control -- among other things that

provided for items A to M, which, if one reads the whole

to me to provide for control, but I just come to the one.

The regulation that provides the framework to be made

made to provisions; that is correct?

HON. MR. DAVIES: Yes.

COMMISSIONER McCUTCHEN: So once those rules

are established, whatever they may be, they cannot sub-

sequently be changed without the approval of the Lieutenant-

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3 to be verified in that sense.

4 COMMISSIONER McCUTCHEON : So, to use your
5 own words to the Chairman a minute ago, the situation
6 could arise where having regard to the situation in which
7 the Province finds itself economically it would not approve
8 an increase in physicians' fees even though recommended
9 by the Commission? Let us say an unenlightened Government?

10 HON. MR. DAVIES: In difficult times there
11 would be a recognition of this by all parties in the
12 population. It seems to me in this area that we are on the
13 horns of a dilemma. We are criticized on the one hand
14 for not having enough money in funds to meet this and on
15 the other hand it is suggested that we will not in some
16 manner allow enough money to the persons who are giving
17 the service for the service they render. I think this is
18 a point, the result in the long-run, that the pressures
19 of Government demand a good standard of medical care and
20 this seems to be the opinion of authorities.

21 COMMISSIONER McCUTCHEON: My question was a
22 very simple one, that situation I have put to you could
23 arise?

24 HON. MR. DAVIES: That situation could
25 arise but I do not anticipate it will arise.

26 COMMISSIONER McCUTCHEON: Well then, can you
27 describe any more effective way of controlling a group of
28 people and to control their incomes by Government?

29 HON. MR. DAVIES: Is your question that you
30 want us to suggest an alternative means of doing it?

COMMISSIONER McCUTCHEON: I am suggesting you have the
most effective control of the medical profession and it



to be verified in that sense.

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4 can control every aspect of its work under the terms of
5 this Act and under the right of the Lieutenant-Governor-
6 in-Council to approve of regulations that Commission might
7 make.

8 HON. MR. DAVIES: I will say this: I do not
9 think that under any system of public medical care the
10 income of physicians has suffered. In fact, I think the
11 tendency has been in the other direction. In the pilot
12 plant we have in this Province, the Swift Current scheme,
13 the salaries of physicians have not suffered but have been
14 in an upward direction. I think that is the situation
15 wherever public plans have resulted.

16 COMMISSIONER McCUTCHEON: It is conceivable
17 that having regard to the position in which the Province
18 might find itself economically that you would find yourself
19 with a scale materially lower than the scale, say, in
20 British Columbia or Ontario? That is conceivable, is it?

21 HON. MR. DAVIES: I suggest your economic
22 situation might be worse than it was in British Columbia
23 and you could pay the same or higher, it depends on what
24 decision you make on how much you are going to spend of
25 your income for this purpose. There is no reason to sug-
26 gest it would necessarily be lower.

27 COMMISSIONER McCUTCHEON: I do not suggest
28 necessarily but I say that situation could arise?

29 HON. MR. DAVIES: Yes, I think it could arise.

30 COMMISSIONER McCUTCHEON: And if it did arise
it might result in a decrease in the quality of medical
care through fewer physicians being willing to practise
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that having regard to the position in which the Province might find itself economically that you would find yourself with a scale materially lower than the scale, say, in British Columbia or Ontario. That is conceivable, is it?

HON. MR. DAVIES: I suggest your economic situation might be worse than it was in British Columbia and you could pay the same or higher, it depends on what decision you make on how much you are going to spend of your income for this purpose. There is no reason to suggest it would necessarily be lower.

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3 HON. MR. DAVIES: I think this, that in a
4 bad economic situation you are more likely to find the
5 quality of medical care and the salaries of physicians
6 suffering because of the lack of public medical care
7 programmes than because of the presence of it. The presence
8 a public medical care programme is apt to outline and
9 underscore the income of physicians and the services that
10 are received by the general public.

11 COMMISSIONER McCUTCHEON: Thank you. That
12 really was not what I was asking. One final question.
13 I think I have you quoted correctly when you referred
14 yesterday to persons in the Province diseased because
15 they cannot afford medical care. What evidence have you
16 that persons unable to afford medical care, "afford" is
17 a relative term, people can afford television sets and
18 not premiums, but what evidence have you that diseased
19 -- there are people in this Province who are diseased
20 because they have gone to a doctor and have been refused
21 medical care.

22 HON. MR. DAVIES: I would say this, that
23 our assertion here would rest on the income of the people
24 of the Province.

25 COMMISSIONER McCUTCHEON: In other words,
26 it is an assumption?

27 HON. MR. DAVIES: Yes, and I think that is
28 an assumption that rests on some pretty solid facts. We
29 are not suggesting a physician has ever turned down a
30 patient that goes to him because he is in need of care
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5 Sickness Survey of 1951 means anything it shows that
6 there is more sickness and ill health residual in the
7 lower income group than in the higher income group. This
8 again we think is indicative of the point I make that
9 people do not go to the doctor when they do not have the
10 means to pay. I agree with you when you say there are
11 some sections that can pay but do not pay but you are
12 talking of the section that because of the income position
13 clearly are not in the same good position.

14 COMMISSIONER McCUTCHEON: Thank you very much.

15 THE CHAIRMAN: Mr. Davies, you have a very
16 nice printed copy of the interim report, will that be
17 obtainable from the Queen's Printer?

18 DR. ROTH: I feel quite confident that we
19 sent these to Ottawa and I apologize if they have not
20 arrived.

21 THE CHAIRMAN: There are easier to carry
22 around than the big ones.

23 DR. ROTH: I will see the Commission gets
24 them here.

25 THE CHAIRMAN: Mr. Davies, and those associ-
26 ated with you, I think we have completed the enquiries
27 so far as you are concerned and I suppose you are quite
28 pleased about that. There is just one observation you
29 made that I would like to refer to and that is when you
30 say "We are being criticized." Now, if by that you
mean that this interrogation has involved criticism then
I suggest that that was not a correct statement to make.
You see, the reason that we must probe into the nature



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3 of a compulsory scheme and its implications is because
4 you advocated that not only for Saskatchewan but for all
5 the other provinces of Canada and, therefore, we have to
6 probe the implications for each province even though in
7 making that enquiry may to you have a semblance of criti-
8 cizing your programme.

9 HON. MR. DAVIES: May I say I am referring
10 here generally to what we all read in the newspapers,
11 what appears in the Press in the news media and I am sure
12 we are all aware of it. That is what I was referring to
generally.

13 THE CHAIRMAN: You can understand the fact
14 this discussion is going on would not be enough to prevent
15 this Commission from pursuing its enquiries even though it
16 may be subject to criticism by some of indulging in
criticism of you.

17 HON. MR. DAVIES: Quite so and we accept all
18 your questions and have done our best to answer them. If
19 there are more questions that you subsequently would like
20 to have answered, we will try to answer them.

21 THE CHAIRMAN: As I said at the outset, we are
22 appreciative of your co-operation, the courtesy of your
23 presentation and the courtesy of your Commission through-
24 out the whole of yesterday and this morning. We want to
25 extend to you the thanks of the Commission for your at-
26 tendance here and for the help you have been to us. Thank
you very much.

27 HON. MR. DAVIES: May I say we appreciate
28 having been here and we thank you for the interest that you
29 have shown in our brief.
30

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may be subject to criticism by some. I am insisting on
criticism of you.

HON. MR. DAVIES: Quite so and we accept all

your questions and have done our best to answer them. If
there are more questions that you subsequently would like
to have answered, we will try to answer them.

THE CHAIRMAN: As I said at the outset, we are

of your co-operation, the courtesy of your
presentation and the courtesy of your commission through-
out the whole of yesterday and this morning. We want to
extend to you the thanks of the Commission for your at-
tendance here and for the help you have been to us. Thank
you very much.

HON. MR. DAVIES: Now I say we appreciate

having been here and we thank you for the interest that you



THE CHAIRMAN: We will now proceed with a submission of the Canadian Mental Health Association, Saskatchewan Division and this will be Exhibit 79.

---EXHIBIT NO. 79: Submission of Canadian Mental Health Association, Saskatchewan Branch.

SUBMISSION OF CANADIAN MENTAL HEALTH ASSOCIATION
SASKATCHEWAN BRANCH

APPEARANCES:

REV. P.S. KINLIN - Vice-President

MR. I.J. KAHAN - Executive Director

MRS. R.J. DAVIDSON - Former President

PROF. D.B. BLEWETT

DR. A. HOFFER

FATHER KINLIN: Mr. Chairman, I do not know whether you wish us to read the complete summation or whether you wish us to outline the general purpose of the statement and possibly answer questions on different parts of the brief.

THE CHAIRMAN: Father Kinlin, procedure has been -- but we leave it to you ultimately -- that if you would synopsize the brief, the relevant points you wish to make in particular and give in detail any recommendations that you have to put forward.

FATHER KINLIN: Mr. Chairman, our brief is based upon our contention that the mentally ill should be entitled to the same level of care as accorded to the



THE CHAIRMAN: We will now proceed with a sub-
mission of the Canadian Mental Health Association, Saskatoon
Division and this will be Exhibit 73.

---EXHIBIT NO. 73: Submission of Canadian Mental Health

SUBMISSION OF 6A

ATTORNEYS:

MR. J. C. KILIAN - Executive Director

MR. A. HORTON

FATHER KILIAN: Mr. Chairman, I do not know
whether you wish to read the complete submission or
whether you wish us to outline the general purpose of the
statement and possibly answer questions or different parts
of the brief.

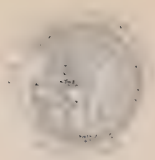
THE CHAIRMAN: Father Kilian, procedure has
been -- but we leave it to you ultimately -- that if you
would synopsize the brief, the relevant points you wish to
make in particular and give in detail any recommendations
that you have to put forward.

FATHER KILIAN: Mr. Chairman, our brief is
based upon our contention that the mentally ill should be
entitled to the same level of care as accorded to the



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3 physically ill. Possibly we should say that since we are
4 dealing with matters of the mind that the mentally ill are
5 entitled to a greater degree of care than a person suf-
6 fering from some physical disability.

7 In our brief we have given, first of all, the
8 historical basis or development of the association. I
9 would like to draw your attention that through the gener-
10 osity of the Federal Government the Saskatchewan Division
11 was the first Provincial Division established and was done
12 so with the aid of a grant from the Federal Government.
13 Unfortunately that grant is not being continued. We have
14 attempted to point out the reason for our association and
15 it is basically the fact that the mentally ill historically
16 in this province as well as elsewhere have
17 not received the same degree of care as has been given to
18 other ill persons. There is, of course, the old stigma
19 attached to a person who is or has been mentally afflicted.
20 Our brief does give the facts and figures to substantiate
21 our figures. There is one particular phase of this that I
22 do think commands attention and that is that the psychiatrist,
23 psychologists, working with the mentally ill have been
24 handicapped because they have been working because of dedi-
25 cation rather than by the inducement of comparative
26 salaries with people engaged in other phases of the medical
27 field. I would like to go to the last page of our brief
28 to the recommendations which I would like to submit to the
29 Commission for their consideration. The first is that
30 the Federal Government's participation in payment for the
hospitalization for the mentally ill should be on the same
basis as for the physically ill. We know this has not been
the case.



physically ill. Possibly we should say that since we are dealing with matters of the mind that the mentally ill are entitled to a greater degree of care than a person suffering from some physical disability.

In our brief we have given, first of all, the historical basis or development of the association. I would like to draw your attention that through the generosity of the Federal Government the Saskatchewan Division was the first Provincial Division established and was done so with the aid of a grant from the Federal Government. Unfortunately that grant is not being continued. We have

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rather rather than by the treatment of comparative salaries with people engaged in other phases of the medical field. I would like to go to the last page of our brief to the recommendations which I would like to submit to the Commission for their consideration. The first is that



We would also like to recommend Federal Government establishment of adequate standards and accurate accreditation to medical hospitals.

Encouragement and provision of funds for the inauguration of the Saskatchewan plan on a national basis.

For the moment I would like to digress and speak of the Saskatchewan plan. This plan was proposed by psychiatrists in Saskatchewan and it is based upon the principle of a small unit or small mental hospital located in areas that would be accessible to the relatives of the patients. I believe that Ontario has inaugurated certain phases of this plan and it has become known as the Saskatchewan plan. In 1960 the Provincial Government announced the initial step in the implementation of this plan with the proposed erection of a psychiatric unit in Yorktown. Unfortunately, the money has not been made available for the full implementation of this first unit.

We would like to recommend also an enlightened policy for professional personnel which will include:

(a) Salaries competitive with other workers of equal qualifications and responsibility.

(b) Adequate post-graduate programmes.

We would also recommend a much better worker to patient ratio. In our submission we have pointed out that in the treatment of the mentally ill there is a very heavy case load for each worker.

We would like to recommend levels of care for the mentally ill equivalent to those provided for the physically ill. We would recommend removal of all discrimination against mentally ill by governments and medical insurance agencies. We would recommend the diversion to



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rimination against mentally ill by governments and medical

insurance agencies. We would recommend the diversion to



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3 psychiatry research of four to five percent of the annual
4 expenditure for the treatment of mental illness. We
5 recognize here the Federal Government has in the past
6 made grants available for psychiatric research and we
7 are very happy that in Saskatchewan from the very begin-
8 ning this grant was made use of. I understand that is also
9 being used now in other provinces. We would like to recom-
10 mend an adequate plan for the treatment of the chronically
11 ill including adequate institutions. We would recommend
12 expansion of research into the field of mental retardation
13 and provision of adequate remuneration for general
14 practitioners in the treatment of mental illness.

G/je 14 These, Mr. Chairman and members of the Com-
15 mission are our recommendations for your consideration.
16 Possibly other members of the delegation may wish to add
17 to my remarks.

18 THE CHAIRMAN: Mrs. Davidson, have you some-
19 thing to add?

20 MRS. DAVIDSON: Well, Mr. Chairman, I would
21 like to stress the fact that this is an organization of
22 citizens and scientists, and we feel that only as citizens
23 become aware, through contact, of the problems of the
24 mentally ill, can an effective programme be established.
25 Our organization, through various ways, through the mental
26 hospital visiting, through rehabilitation centres, through
27 visiting such areas as Munroe Wing, have tried to estab-
28 lish a close liaison with the patients, with hospital
29 staff, and so on. We feel that research is a matter of
30 great emergency, because if there could be a break-through
with respect to such diseases as schizophrenia and alco-
holism, a great deal of unhappiness, a great deal of





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4 economic waste, could be avoided.

5 We have an excellent team in Saskatchewan,
6 that is supported not only by Federal Grants, but by
7 Provincial grants, and by grants from foundations. We
8 are also interested in the research for retardation, be-
9 cause of the large percentage, two to three percent of
10 the population are mentally retarded, and this is a prob-
11 lem that may be linked to certain physical and genetic
12 factors, that through research could either be helped or
perhaps could be prevented, sir.

13 MR. KAHAN: I haven't very much to add, Mr.
14 Chairman. I just want to say that we have concentrated
15 on conditions as they are in Saskatchewan. We believe,
16 or have reason to believe, that conditions are somewhat
17 similar, or worse, in other provinces. That is all at
the present.

18 THE CHAIRMAN: Now, we have a few questions
19 that we would like to ask in explanation of your brief,
20 and it won't be necessary to stand up to answer these,
21 if you prefer. You said that your activities were --
began with the help of a Federal grant?

22 MRS. DAVIDSON: And a provincial grant, Mr.
23 Chairman.

24 THE CHAIRMAN: And I take it that these were
25 more or less matching grants at the time?

26 MRS. DAVIDSON: They were grants on a dimini-
27 shing basis.

28 THE CHAIRMAN: And the Federal grant is
29 exhausted?

30 MRS. DAVIDSON: Well, for some time we have

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4 a grant for three years, but because of the Federal
5 financial year and our year, it ran on for another six
6 months, the Provincial grant was continued probably for
7 four years, but since that time we have been entirely on
8 our own financially.

9 THE CHAIRMAN: Now, where do you get your
10 funds?

11 MRS. DAVIDSON: Well, the first campaign was
12 in 1953.

13 THE CHAIRMAN: No, but I mean as of now?

14 MRS. DAVIDSON: Well, through a drive in
15 February, through United Appeals, through private don-
16 ations.

17 THE CHAIRMAN: What is your budget for the
18 year in Saskatchewan?

19 MRS. DAVIDSON: Well, it is close to a hundred
20 thousand.

21 THE CHAIRMAN: So that it is a substantial
22 undertaking?

23 MRS. DAVIDSON: That is right.

24 THE CHAIRMAN: Now, dealing specifically with
25 some of your recommendations, and particularly with No.
26 7, where you say you advocate removal of all discrimination
27 against mentally ill by Governments and medical insurance
28 agencies would you care to expand on that, just what you
29 mean by that?

30 MR. KAHAN: Yes, Mr. Chairman. Actually many
private agencies, and some public agencies, insurance
agencies, that is, medical insurance agencies, have a



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3 clause in the contract which says that they will not pay
4 for a psychiatric disability, for psychiatric treatment.
5 In other words, psychiatric treatment is excluded from
6 many of their contracts.

7 THE CHAIRMAN: Is it included or excluded on
8 their group medical service in M.S.I., do you know?

9 MR. KAHAN: I believe it is excluded.

10 THE CHAIRMAN: You heard the Minister this
11 morning say it is now within the definition of medical
12 services under the new Service Act?

13 MR. KAHAN: Yes, sir.

14 FATHER KINLIN: Mr. Chairman, the question,
15 it is specifically stated in the Act that mentally ill
16 shall be included. I think there is something to the
17 effect that the interpretation is that the psychiatrist
18 would be classed more or less as other specialists, and
19 if a patient is referred to him by the general practitioner
20 that this phase of his care would be covered.

21 THE CHAIRMAN: And you are apprehensive that
22 that would be too limited?

23 FATHER KINLIN: I suspect that it would not
24 be quite adequate to cover the full need, or demand.

25 THE CHAIRMAN: Then I revert to page 10, in
26 the second last paragraph, you open with this statement:
27 "There is absolutely no doubt that the standards of care
28 are abysmally low no matter what criteria of care are
29 used in the evaluation. The mentally ill in Saskatchewan
30 are second class citizens. " Then you open the next
paragraph: "The departments of public health have two
sets of standards for health care. One set of standards

classes in the contract which says that they will not pay for a psychiatric disability, for psychiatric treatment. In other words, psychiatric treatment is excluded from many of their contracts.

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MR. KAHAN: I believe it is excluded.

THE CHAIRMAN: You heard the witness this morning say it is not within the definition of medical services under the new Service Act?

MR. KAHAN: Yes, sir.

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THE CHAIRMAN: Then I revert to page 10 in the second last paragraph, you can read this statement: "There is absolutely no doubt that the standards of care are abnormally low no matter what criteria of care are

are second class citizens." Then you open the next paragraph: "The departments of public health have two sets of standards for health care. One set of standards



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4 (and these are very admirable) they enforce on all general
5 hospitals. Another set of standards (much inferior) apply
6 to their own mental hospitals. Do you wish to amplify
7 that, because these are statements that are of some con-
8 sequence, and we would like to know on what in fact they
9 are based?

10 MRS. DAVIDSON: Mr. Chairman, in this Province
11 and in many others the population in the hospitals are
12 much greater than they should be. Not only are they
13 greater than they should be, but large groups of patients
14 are in one ward. You can imagine, if you were a fearful
15 person, if you were put in a ward of from 75 to 100, it
16 would be very difficult to relate the other patients.
17 I believe that a smaller group of 10 or 15
18 is a group that may readily relate, or a ward of 35 would
19 be a great improvement over wards of 75 and 100. There
20 are very few private rooms.

21 There have been devices used to make the
22 present facilities as good as possible. For instance, in
23 large bed wards, beds have been painted different colours,
24 so that there will be a quarter or a fifth of the room
25 painted in one colour, so that a patient will know--a
26 confused patient especially will know -- in which area he
27 will sleep.

28 There are many devices such as this in large
29 day rooms. The room will be broken by colours, so that
30 the patient will find a little bit of security, his chair,
which he calls his own. The crowding is not so bad as it
was at one time, but it is still bad.

The incidence of germs, I understand in the wards

(and these are very admirable) they enforce on all general hospitals. Another set of standards (much inferior) apply to their own mental hospitals. "Do you wish to amplify that, because these are statements that are of some consequence, and we would like to know on what basis they are based?"

MRS. DAVIDSON: Mr. Chairman, in this Province and in many others the population in the hospitals are much greater than they should be. Not only are they greater than they should be, but large groups of patients are in one ward. You can imagine, if you were a feasting person, if you were put in a ward of from 25 to 100, it would be very difficult to relate the other patients. I believe that a smaller group of 10 or 15 is a group that may readily relate, on a ward of 25 would be a great improvement over wards of 75 and 100. These are very few private rooms.

These have been devised used to make the present facilities as good as possible. For instance, in large bed wards, beds have been painted different colours, so that there will be a quarter or a fifth of the room painted in one colour, so that a patient will know a confused patient especially will know -- in which area he will sleep.

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4 is greater than you will find in a general hospital, be-
5 cause of overcrowded facilities. The incidence of T.B.
6 for instance, is greater in a psychiatric hospital than
7 for patients in a general hospital and this may be due to
8 overcrowding.

9 Wards are placed in basements. I had a phone
10 call last night from a woman quite amazed that there were
11 such things as basement wards. The hospitals are large
12 and massive. They are difficult to administer. It is
13 very difficult for relatives to come and see these
14 patients; when they come to see the patients there is
15 actually no proper place for them to visit with these
16 patients. There is an attempt to help this matter, but
17 it is still one that has not been solved.

18 Now, I may say the staff have done a terrific
19 job. In recent years they have reorganized the hospital.
20 They have changed their methods of procedure, but in spite
21 of this there is a great lack in the hospital, as compared
22 to a general hospital.

23 THE CHAIRMAN: On page 6 there is a reference
24 here to overcrowding, in Paragraph No. 2, the last sentence
25 in the paragraph: "In some of the wards, it is possible
26 to walk across a large room on beds stacked side by side
27 without once touching the floor." Is that an exaggeration
28 or a fact?

29 MRS. DAVIDSON: Well, I was in one hospital,
30 now it is two or three years since, but at that time there
was such a ward that you could roll from one side of the
room to the other.

 THE CHAIRMAN: In the Province there are the



is greater than you will find in a general hospital, because of overcrowded facilities. The incidence of T.B. for instance, is greater in a psychiatric hospital than for patients in a general hospital and this may be due to

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Now, I may say the staff have done a terrific job. In recent years they have reorganized the hospital. They have changed their methods of procedure, but in spite of this there is a great lack in the hospital, as compared

THE CHAIRMAN: On page 5 there is a reference here to overcrowding, in Paragraph No. 5, the last sentence in the paragraph. "In some of the wards, it is possible to walk across a large room on beds stacked side by side without touching the floor." Is that an exaggeration or a fact?

MRS. DAVIDSON: Well, I was in one hospital, now it is two or three years since, but at that time there was such a ward that you could roll from one side of the room to the other.

THE CHAIRMAN: In the Province there are the



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4 two large hospitals, at Weyburn and North Battleford?

5 MRS. DAVIDSON: That is right.

6 THE CHAIRMAN: What is that other institution,
7 that, perhaps called Battleford? The one between the
8 Saskatchewan River and the Battle River, on the flat there?

9 MRS. DAVIDSON: Actually, Mr. Chairman, that
10 is all one institution. It is all under one superintendant,
11 and they have their -- originally I believe it was in-
12 tended for those going in for farming and this sort of
13 thing, but at the present time I believe it is merely
14 curative, and it makes for difficulty in communication
15 between the staffs of the two units, the main unit and
16 the one further away.

17 THE CHAIRMAN: Is it accessible to relatives
18 of patients who may wish to go there to visit their older
19 members of the family who are housed there?

20 MRS. DAVIDSON: Well, the hospitals are all
21 open to visiting. In fact visiting is encouraged, but
22 when you get -- visiting facilities are not good. They
23 are not attractive rooms. In some places you see them
24 visiting in the halls, and staff and patients with
25 you know, parole as it were, are moving back and forth,
26 so it is really quite difficult to visit with a particu-
27 lar person. In the Weyburn Hospital you will note that
28 there are still a large number of defectives; at the time
29 the training school was built it was hoped that all the
30 defectives would be housed in this training school at
Moose Jaw, but there are around 160 of the low-grade
defectives still at Weyburn.

THE CHAIRMAN: Is it the considered view of

two large hospitals, at Weyburn and North Battleford?

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you know, parcels as it were, are moving back and forth,

so it is really quite difficult to visit with a particu-

lar person. In the Weyburn Hospital you will note that

there are still a large number of defectives at the time

the training school was built it was hoped that all the

defectives would be housed in this training school at

Moose Jaw, but there are around 100 of the low-grade

defectives still at Weyburn.

THE CHAIRMAN: Is it the considered view of



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3 your Association that in the long-run the large hospitals,
4 such as at Weyburn and North Battleford, should disappear
5 in favour of some other form of institutional care?

6 FATHER KINLIN: That would be the ideal to
7 hope for. However, we have to realize that these institu-
8 tions were built, and there is a considerable Government
9 investment in those two institutions. We cannot simply
10 scrap them, although that might be our desire. We do
11 feel that the mental health picture will be much improved
12 when we have ten small units in different areas of the
13 Province and this would enable relatives to visit readily,
14 and keep the patients' contact with the outer world.

15 THE CHAIRMAN: I suppose it would have the
16 effect of decreasing the overcrowding in the two larger?

17 FATHER KINLIN: Yes, very definitely. It
18 would relieve the overcrowding, but I believe it has other
19 more positive advantages.

20 THE CHAIRMAN: Do you visualize these units
21 being separate units, or as integrated components of
22 the general hospital system?

23 FATHER KINLIN: I think that the desirability
24 of the psychiatrists in Saskatchewan is that they be com-
25 pletely autonomous units. I realize there are some who
26 favour the unit as a component part of a general hospital.
27 We think that these hospitals should be adjacent to, but
28 not a part of the general hospitals.

29 MRS. DAVIDSON: But that staff, Mr. Chairman,
30 medical staff and facilities could be shared. That is,
there are many ordinary medical problems with respect to
the mentally ill, that you might have a specialist in,



Your Association that in the long-run the large hospital
such as at Lexington and North Hartford, should disappear
in favour of some other form of institutional care.

FATHER HINDIN: That would be the ideal to
aim at, but I think it is a long way off. I think
there are many, many things that are going on in the
investment in these two institutions. We cannot easily

scrap them, although that would be our desire. We do
feel that the mental hospital will be much improved
when we have new mental hospitals and areas of the
Province and this would enable patients to visit readily,
and keep the patients' contact with the community.

THE CHAIRMAN: I suppose it would save the
effect of decreasing the number of the two largest
in the Province, say, very definitely, it

would reduce the overcrowding, but I believe it has other
more positive advantages.
THE CHAIRMAN: In your view as these units

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the general hospital system.
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pletely autonomous units. I realize there are some who
favor the unit as a component part of a general hospital.
We think that these hospitals should be adjacent to, but
not a part of the general hospital.

MR. HINDIN: But that staff, Mr. Chairman,
the mentalist, that you might have a specialist in.



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4 probably cancer, apart from the total staff that could
5 be consulted, X-rays for instance might be shared, and
6 that sort of thing.

7 COMMISSIONER GIRARD: Father Kinlin in the
8 last page, in your recommendations in no. 5, you state
9 there should be a much better worker to patient ratio,
10 and looking at the table on page 7, it seems that the
11 larger discrepancy between the ratio of patients to
12 workers is among nurses. You state here a deficit of
13 1,123 nurses. You are referring to psychiatric nurses,
14 are you?

15 MR. KAHAN: Yes, that is right, psychiatric
16 nurses.

17 COMMISSIONER GIRARD: And a deficit of 46
18 nursing instructors in psychiatric nursing also?

19 MR. KAHAN: Yes.

20 COMMISSIONER GIRARD: Do you have any idea
21 of why this deficit is so high in the number of psychiatric
22 nurses?

23 MR. KAHAN: Actually the situation is getting
24 better. We are training many psychiatric nurses. I
25 think the reason why the deficit is higher in this cate-
26 gory than in the others is that we require many more
27 nurses, for instance the other categories have 59, 70,
28 and so forth, 50, 46, and 26, as a shortage. In the
29 nursing category we require, or requested 2,235, and of
30 course this is quite a number and our training programme
has not as yet caught up with the demand for nurses, but
we do have a very good training programme in Saskatchewan.

Y/je 29 COMMISSIONER GIRARD: Would you feel that the
30



probably cannot, apart from the total staff that could be consulted, X-rays for instance might be shared, and that sort of thing.

There should be a much better working relationship, and looking at the table on page 7, it seems that the larger discrepancy between the ratio of patients to workers is among nurses. You state there a deficit of 1,123 nurses. You are referring to psychiatric nurses, are you?

DEFICIT OF 1,123. And a deficit of 20

nursing instructors in psychiatric nursing also.

Yes, indeed. Yes.

DEFICIT OF 1,123. Do you have any idea

of why this deficit is so high in the number of psychiatric

MR. KAHAN: Actually the situation is getting

better. We are turning away psychiatric nurses. I

don't think in the future it that we require many more

nurses, for instance the other categories have 50, 70,

and so forth, 50, 40, and 30, as a percentage. In the

nursing category we require, as requested 2,335, and of

COMMISSIONER GIRARD: Would you feel that



fact that a psychiatric nurse is trained only in psychiatry and cannot work in any other hospital would be one of the reasons why it would be hard to get students for psychiatric nursing courses?

MR. KAHAN: I don't think that would be a factor because for one thing psychiatric nurses receive payment while in training on an increasing basis: the first year they get a small monthly salary; the second year more; and the third year quite considerable. Secondly, they do get quite a bit of physical medicine background in their training.

COMMISSIONER GIRARD: But can they work in a general hospital, let us say, outside of a psychiatric ward?

MR. KAHAN: No, it would take two years for them to become a registered nurse and work in a general hospital as such.

COMMISSIONER GIRARD: Is there any means by which a psychiatric nurse, if she wishes to, can have credits for her psychiatric training and go into a three year course for an R.N.?

MR. KAHAN: Yes. Actually, I think their training at present is counted as one year. In other words, they only need two years to complete their registered nurses' training.

COMMISSIONER GIRARD: Do you have any registered nurses at all in your psychiatric hospitals?

MR. KAHAN: There are quite a few registered nurses.

COMMISSIONER GIRARD: What would be the



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4 function of the registered nurse in relation to the
5 psychiatric nurse?

6 MR. KAHAN: I am not quite certain about that,
7 but some registered nurses have both degrees or diplomas.
8 They are a registered nurse and also a registered psy-
9 chiatric nurse, and some of them are nursing officers and
10 occupy administrative positions. Also there are some
11 registered nurses who work on the physical side of the
12 hospital: for instance, in the tubercular ward, and so
13 forth.

14 COMMISSIONER GIRARD: There is in the Ten
15 Giant Steps an article on nursing in Saskatchewan by Dr.
16 McKerracher, and in that article there is one paragraph
17 which says, "Much has been done during the past ten years
18 to improve the training and to find better ways to use
19 this excellent group of people in treating the mentally
20 sick." I think it is referring to the psychiatric nurse.
21 "With the new emphasis on community participation in
22 psychiatric treatment, what will the roll of the psychia-
23 tric nurse be in the future?" Do you have any idea of
24 what is implied in this?

25 MR. KAHAN: I think generally the philosophy
26 has been to take the mental hospital into the community,
27 as it were, and to have a greater participation of every-
28 one in the community in the treatment of the mentally ill.
29 For instance, in our visiting programme and so forth.
30 The Saskatchewan plan envisages really a psychiatric
centre or psychiatric community resource in which there
would be out-patient and in-patient treatment, and also
community education: that is, people from the psychiatric



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4 centre, from the hospital, will be able to go into the
5 community and give lectures and so forth and also dis-
6 cussion groups, and this, I believe, would improve the
7 nurses: the psychiatric nurse would be able to parti-
8 cipate in the community -- not only going out to the
9 community but trying to get people from the community
into the hospital.

10 MRS. DAVIDSON: Mr. Chairman, it seems to me
11 one of the reasons it is difficult to get psychiatric
12 nurses is this matter of prestige. A girl who becomes
13 a registered nurse has a considerable amount of prestige.
14 The hospital I visit in, and the other hospitals, have
15 graduation exercises to help this matter of prestige,
16 but until this discrimination against the mentally ill
17 is removed there is going to be a down-grading of people
18 working in the mental hospitals, and if you have worked
19 on these wards or visited as volunteers you will under-
20 stand these young people are up against terrific prob-
21 lems, and it always amazes me how well they accept these
22 responsibilities. Many people who are not emotionally
or temperamentally fitted for psychiatric nursing may
be quite good general hospital nurses.

23 COMMISSIONER BALTZAN: Father Kinlin and
24 others, I am going to make my questions very short, and
25 it is only relative to the Province of Saskatchewan.
26 No. 1, I see repeated reference to the quality of care
27 of the mentally ill. My question is, is it due at least
28 in part to the number of total personnel at all levels?
Is your answer yes or no?

29 FATHER KINLIN: Yes, in part.
30

centre, from the hospital, will be able to go into the community and give lectures and so forth and also discuss groups, and this, I believe, would improve the nurses: the psychiatric nurse would be able to participate in the community -- not only going out to the community but trying to get people from the community into the hospital.

Mrs. DAVISON: Mr. Chairman, it seems to me

one of the reasons it is difficult to get psychiatric nurses is this matter of hospital. A nurse who becomes a registered nurse has a considerable amount of training. The hospital I visit in, and the other hospitals, have graduation exams to help this matter of practice, but until this examination system is mentally ill is removed there is going to be a downgrading of people working in the mental hospitals, and if you have worked on these wards or visited at all, you will understand that these young people are in a very difficult position, and I always wonder how will they accept these responsibilities. Many people are not emotionally so temperamentally fitted for psychiatric nursing as to give good general hospital nurses.

others, I am going to make my questions very short, and it is only relative to the Province of Saskatchewan. No. 1, I can repeat reference to the quality of care of the mentally ill. My question is, is it one at this in part to the number of staff personnel at all levels? Is your answer yes or no?



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4 COMMISSIONER BALTZAN: Then, could it also be
5 in part due to a lack of sufficient financial support to
6 these institutions, and you mention salaries, that also
obtains here?

7 FATHER KINLIN: Yes.

8 COMMISSIONER BALTZAN: And lastly -- and this
9 is not to be tricky to anybody -- the mental hospitals
10 are both provincial -- mostly -- and also with Federal
11 support, and they differ generally from the management
12 of other hospitals. Would there be any reason to think
13 that because the hospital care is under the auspices of
14 Government, Federal or Provincial, that there is that
15 difference? I don't mean any reflection, but it is a
16 question of the state-run hospital versus the community
hospital versus the general hospital etcetera?

17 FATHER KINLIN: I don't think that specifically
18 is the cause. Possibly the greater cause is that these
19 institutions were established more or less for custodial
care and not for medical care.

20 COMMISSIONER BALTZAN: That helps me a lot.
21 One other point: I see a reference to the Yorktown
22 Hospital here: has it been completed?

23 FATHER KINLIN: No, it has not.

24 COMMISSIONER BALTZAN: Have you any reason
25 that there is this slow motion, that you know of?

26 FATHER KINLIN: The reason given to us is the
lack of available money for this project.

27 COMMISSIONER BALTZAN: The lack of available
28 funds to complete the project: it was started, but it
29 has not been finished.
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I have one other question: on page 7:
"Number of indicated personnel in Saskatchewan.", and I
am not going into detail. I just want to ask you this:
there is a request for so many, an authorization for so
many: who requests and, second, who authorizes?

MR. KAHAN: These requests, Mr. Chairman, are
put out as standard by the American Psychiatric Associ-
ation. The authorization is given by the Government in
setting up their establishment for their institutions.

COMMISSIONER BALTZAN: You go by the general
standards --

MR. KAHAN: Of the American Psychiatric
Association.

COMMISSIONER BALTZAN: Not exactly emanating
from Saskatchewan?

MR. KAHAN: That is right.

COMMISSIONER BALTZAN: On page 8, the first
two lines: "This situation..." -- referring to standards
-- "is intolerable and will require continuing exertion
in bringing strong pressure upon Government," etcetera.
Could you say why you have to continually exert this
pressure? Is the Government conscious of these things?

MR. KAHAN: Yes, I believe they are conscious.
In fact, I am sure they are, but I think generally a
Government will go along with what they believe people
want, and therefore we have to demonstrate to them that
people want these improvements.

THE CHAIRMAN: It is the squeaking wheel that
gets the grease.

COMMISSIONER BALTZAN: In the same context on



I have one other question: on page 1:

"Number of indicated personnel in 'black' category."

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standard.

standard.

MR. KAHN: Is the American Psychological

Association?

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4 page 11: "The medical profession of Saskatchewan has
5 been as forward and progressive as all other associations
6 in dealing with the mentally ill." My question again is,
7 who is in the way of achieving your objectives, or the
8 objectives of the medical association?

9 MR. KAHAN: Well, I believe the reasons given
10 are financial: that it would cost a very great deal to
11 establish the Saskatchewan plan in Saskatchewan. Secondly,
12 to get enough personnel, the cost would be very high; we
13 realize that. However, we feel that it would still be
14 well worth it and would repay not only in financial ways
15 but other ways as well.

16 COMMISSIONER BALTZAN: The answer lies in the
17 pocket, then?

18 MR. KAHAN: I would say so.

19 THE CHAIRMAN: What you mean is that there is
20 just so much money and priorities have to be determined
21 and various needs taken care of in terms of priorities.
22 In the judgment of the Canadian Mental Health Association,
23 what would your judgment be in the matter of priority,
24 the needs of the mentally ill in Saskatchewan, or the
25 bringing into being of the Medical Care Plan?

26 FATHER KINLIN: Mr. Chairman, I don't think
27 we as an association would like to commit ourselves on
28 the feasibility or non-feasibility of the Medical Care
29 Plan.

30 THE CHAIRMAN: I am not asking that, Father
Kinlin. It is a question of money. We have been told
you may have one or the other; you will have one, and
two or three years from now have another segment of it,



Page 11: "The medical profession of Saskatchewan has

who is in the way of achieving your objectives, or the
objectives of the medical association.

MR. KADAN: Well, I realize the reasons given
are financial; that it would cost a very great deal to
establish the Saskatchewan plan in terms of staff, secondly
to get enough personnel, the cost would be very high; we
realize that. However, we are not at all sure that it
will work it and would mean a lot in financial ways
but other ways as well.

COMMISSIONER KADAN: The answer lies in the

MR. KADAN: I would say no.

THE CHAIRMAN: What you mean is that there is
just so much money and that it is not to be determined
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saying it is a question of money. We have seen to it
you may have one or the other; you will have one, and
two or three years from now have another system of it.



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3 and following on. It is a matter of priorities in terms
4 of economic capacity. So, in your judgment, where should
5 the money be spent now?

6 FATHER KINLIN: In our opinion, the money is
7 needed now to take care of the mentally ill, and this
8 should take priority over every other possible channel
9 through which Government does spend money.

10 THE CHAIRMAN: That is your considered view?

11 FATHER KINLIN: First priority, yes.

12 COMMISSIONER VAN WART: Father Kinlin, would
13 you submit to us a balance sheet for last year so we can
14 see where your funds come from and how you spend them?

15 FATHER KINLIN: Yes, very readily.

16 COMMISSIONER VAN WART: On page 3 you make
17 mention of a volume called Ten Giant Steps, and on page
18 15 in the chapter entitled, "The Saskatchewan Plan" --
19 could you see that our Research Division has available
20 a copy of the Ten Giant Steps with the details of the
21 Saskatchewan Plan?

22 FATHER KINLIN: I would be very happy to
23 supply those.

24 COMMISSIONER STRACHAN: Have you any male
25 nurses in the mental institutions?

26 MR. KAHAN: Yes, quite a few.

27 MRS. DAVIDSON: In fact, some wards have not
28 had women on them until recent years.

29 COMMISSIONER STRACHAN: Are their salaries
30 sufficient for a family man?

MR. KAHAN: I don't know how to answer that
question. Actually the salaries of nurses are low, and



and following on, it is a matter of priorities in terms
of economic capacity. So, in your judgment, where should
the money be spent now?

MR. KILLIAN: In my opinion, the money is
needed now to take care of the mentally ill, and this
should take priority over every other possible channel
through which Government does spend money.

MR. CHAIRMAN: That is your considered view.
MR. KILLIAN: First priority, yes.
MR. CHAIRMAN: Would you submit to us a balance sheet for last year as we can
see where your money came from and how you spend it?

MR. KILLIAN: All right. On page 2 you make
mention of a report called "The Mental Health Division
in the Budgetary Process," which is a report of the
Mental Health Division and is available.
A copy of the report is being sent with the details of the

MR. KILLIAN: I would be very happy to
provide you with a copy of the report.
MR. CHAIRMAN: Thank you very much.
MR. KILLIAN: Yes, sir.

had women on their staffs in recent years.
sufficient for a family man?
question. Usually the salaries of nurses are low, and



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3 I don't believe there is a differentiation between male
4 and female nurses.

5 COMMISSIONER GIRARD: Are they registered
6 nurses?

7 MR. KAHAN: Psychiatric nurses.

8 THE CHAIRMAN: Well, Father Kinlin, Mrs.
9 Davidson and Mr. Kahan, we are particularly grateful to
10 you for your presentation here this morning, and before
11 you leave I thought maybe you and your Association would
12 be interested in knowing that the subject of mental health
13 is one to which this Commission is giving a great deal of
14 attention to the extent that we have commissioned two
15 special studies into the subject, and these studies are
16 being done by Dr. Richmond of the University of British
17 Columbia and by Dr. McKerracher of Saskatoon, whose name
18 is mentioned several times in your own brief this morning.
19 So that it is the intent of the Commission to have quite
20 exhaustive studies made of the subject of mental health,
21 the changing patterns of treatment and custody and so
22 forth. So, that is an additional reason why we are
23 grateful for your presentation here this morning.

22 FATHER KINLIN: I wish to thank you, Mr.
23 Chairman, and members of the Commission and I may say
24 in the name of the Association that I welcome these
25 latter remarks of you, Mr. Chairman, and we can only wish
26 that our presentation would support everything that
27 these special investigators will come forward with.

28 THE CHAIRMAN: We are always interested in
29 having the views of the lay people, as we call them in
30 this area, because it is accepted far and wide that there



and female nurses.

MR. KATANA: Psychiatric nurses.

Davidson and Mr. Kahan, we are particularly grateful to you for your presentation for this morning, and before you leave I thought maybe you and your Association would be interested in knowing that the subject of mental health

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the changing pattern of treatment and care and so forth. So, that is an additional reason why we are grateful for your presentation this morning.

THE CHAIRMAN: I wish to thank you, Mr. Chairman, and members of the Commission and I may say in the case of the Association that I welcome these latter remarks of you, Mr. Chairman, and so on only that that our presentation would support everything that these special investigators will come forward with.

THE CHAIRMAN: We are always interested in having the views of the lay people, as we call them in this area, because it is accepted for and also that they



is a great function for the voluntary association and the volunteer in this type of illness and in, of course, many others in Canada.

FATHER KINLIN: Thank you.

---A SHORT RECESS

COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN
CANADIAN MEDICAL ASSOCIATION, SASKATCHEWAN DIVISION

APPEARANCES:

DR. H.D. DALGLEISH -

President, College of Physicians & Surgeons of Saskatchewan and the Canadian Medical Association, Saskatchewan Division, Member, Executive Committee, Canadian Medical Association.

DR. J.F.C. ANDERSON -

Past President, College of Physicians and Surgeons of Saskatchewan, and the Canadian Medical Association, Saskatchewan Division and Past President C.M.A.

DR. E.W. BAROOTES -

Member of Council, College of Physicians & Surgeons of Saskatchewan, Member, Canadian Medical Association, Economics Committee.

DR. T.E. HUNT -

Professor of Physical Medicine, University of Saskatchewan, Chairman of the Section on Rehabilitation Medicine, College of Physicians and Surgeons of Saskatchewan.

DR. F.S. LAWSON -

Director of Psychiatric Services, Department of Public Health, Province of Saskatchewan.



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3 DR. G.W. PEACOCK -

4 Registrar, College of Physicians & Surgeons
5 of Saskatchewan, Secretary, Canadian Medical
6 Association, Sask. Division.

7 DR. M.H. SMITH-WINDSOR -

8 Chairman of Briefing Committee of the
9 College of Physicians & Surgeons of
10 Saskatchewan.

11 DR. J.D. STEPHEN -

12 Director of Laboratories, Regina General
13 Hospital, President, Saskatchewan Association
14 of Pathologists.

15 DR. A.D. KELLY -

16 General Secretary, Canadian Medical
17 Association.

18 MR. B.E. FREAMO -

19 Secretary, Economics, Canadian Medical
20 Association.

21 THE CHAIRMAN: Are you the spokesman, Dr.
22 Dalglish?

23 DR. DALGLEISH: Yes, Mr. Chairman. Mr.
24 Chairman and members of the Royal Commission, the
25 Profession is very privileged that we may come before
26 you today and discuss the health needs of the people of
27 this Province, our patients.

28 Now, Mr. Chairman, Dr. Smith-Windsor will
29 read our summaries and recommendations because he is the
30 head of our drafting committee.

DR. SMITH-WINDSOR:

The attached submission of the College of
Physicians and Surgeons of Saskatchewan (Canadian



DR. C.W. BLACKOCK -

Registrar, College of Physicians & Surgeons

Chairman of Refining Committee of the
College of Physicians & Surgeons of

DR. J.A. SIMON -

MR. H.B. TAYLOR -

Secretary, Honorary, Canadian Medical

THE CHAIRMAN: And for the speaker, Dr.

Colin Clark

Profession is very privileged that we have before
you today and discuss the health needs of the people of
this Province, our patients.
Dr. H.B. TAYLOR, Mr. Simon-Wilson will
read our subject and recommendations because he is
head of our drafting committee.

DR. SIMON-WILSON:

be attached submission of the College of
Physicians and Surgeons of Saskatchewan (Canadian



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3 Medical Association, Saskatchewan Division) undertakes
4 to outline for the Royal Commission on Health Services
5 the views of the medical profession of this province on
6 certain aspects of health services as we can see them.

7 For the past two years we have been studying
8 very closely our health problems because inquiries have
9 been proceeding on a provincial basis. The consequences
10 of our appraisal has been to indicate clearly the ser-
11 vices and facilities which require strengthening and our
12 recommendations listed in order of need are as follows:

13 Mental Health Services

14 The institutional care and treatment of pat-
15 ients suffering from mental illness constitutes a major
16 deficiency in our health services. The methods con-
17 sidered adequate in the past are not satisfactory in the
18 light of current knowledge of mental disturbances and a
19 new approach is required. The essentials of a progres-
20 sive program are contained in the so-called 'Saskatchewan
21 Plan' which unfortunately has not been implemented.
22 Stated briefly, it is recommended that eleven psychi-
23 atric units be constructed in close proximity to, or
24 within selected general hospitals throughout the province
25 and that these facilities be regarded as the main centres
26 for both in-patient and out-patient diagnosis and treat-
27 ment. It is clearly recognized that facilities in the
28 form of buildings will not per se improve our mental
29 health services and that skilled personnel representative
30 of all disciplines related to psychiatric care are more
important. The needs of this province are clear and in
order to attract and retain the essential personnel it is



to outline the Royal Commission on Health Services

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For the past two years we have been studying

very closely our health problems because agencies have

been proceeding on a provincial basis. The consequences

of our approach has been to indicate clearly the cor-

rect and facilities which require strengthening and our

recommendations listed in a series of reports are as follows:

The institutional care and treatment of patients

is suffering from certain illness constitutes a major

deficiency in our health services. The methods con-

sidered elsewhere in the past are not satisfactory in the

light of current knowledge of mental disturbances and a

new approach is required. It is essential that a proper

program be contained in the so-called 'Saskatchewan

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and units be constructed in close proximity to, or

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form of buildings will not so improve our mental

health services and that skilled personnel representative

of all disciplines related to psychiatric care are

important. The needs of this province are clear and



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3 necessary to make a start on the creation of a climate
4 of work which will permit the mental health services to
5 develop progressively towards a new standard of
6 excellence.

7 Our first recommendation is that the con-
8 struction of eleven 200-bed psychiatric units, in con-
9 junction with regional general hospitals, be proceeded
10 with in the immediate future. We estimate that the
11 capital cost of the whole program would approximate
12 \$22 million and that additional maintenance costs would
13 reach a maximum of \$7.6 million annually. The use of the
14 Hospital Construction Grant to its fullest extent would
15 provide substantial Federal Aid in capital expenditure
16 and an amendment of the Hospital Insurance and Diag-
17 nostic Services Act to include as sharable costs the
18 maintenance of patients in mental hospitals, would be
19 desirable.

20 Chronic, Convalescent and Geriatric Facilities

21 The care and rehabilitation of patients suf-
22 fering from chronic disabilities, the restoration of
23 patients following acute illness and injury and the care
24 of our aging population have elements in common which
25 demand institutional facilities of a specialized kind.
26 We are aware of gross shortages in each of these cate-
27 gories and it is our view that planning under a single
28 department of government would be desirable to avoid the
29 haphazard and uncoordinated development of each facility
30 in response to widespread demand. In the absence of the
facilities mentioned, far too many of the beds in acute
treatment hospitals are occupied for lengthy periods



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haphazard and uncoordinated development of each facility
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facilities mentioned, far too many of the beds in ex-



by patients who could be more adequately and less expensively cared for in alternative accommodations. The studies which are currently proceeding by the Survey Committee on the Aged and Long-term Illness will doubtless specify the type and the location of the facilities which are necessary. In the absence of the findings of the survey it is difficult to be precise as to the costs involved. However, the need is unquestioned and we estimate that to meet it, expenditure of public funds in the following approximate amounts will be required.

950 beds for the accommodation of convalescent patients and those requiring practical care for chronic disabilities

<u>Capital Cost</u>	<u>Annual Additional Maintenance Costs</u>
\$9,500.00	\$3,883,600.00

Active Treatment Beds in General Hospitals

We have pointed out the anomalous situation of an acute shortage of general hospital beds in many important centres, despite the generally favorable ratio of beds to the population generally. The demands of our people for admission to hospital is perhaps one result of this lengthy experience with Hospital Insurance but, whatever the cause, waiting lists are long in Regina and Saskatoon and the need for additional general hospital beds is evident in nine other centres of population. It is recognized that if accommodation for the chronic and convalescent were available, the pressure in general hospitals would decrease but the situation as it exists prompts us to recommend that 1600 additional general



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 prompts us to recommend that 1600 additional general



hospital beds are required. The renovation of obsolete accommodation in many of our older general hospitals is also a foreseeable need. We estimate that capital expenditures, provided partly under the Hospital Construction Grant, will be approximately as follows:

1600 active treatment beds	\$24,000,000
Renovation of obsolete institutions	\$10,000,000

Medical Services Insurance

In assessing the health needs of our province we place in fourth priority the expansion of medical services insurance to make benefits available to all residents. After a great deal of study of this matter it is the considered opinion of the College of Physicians and Surgeons of Saskatchewan that medical services insurance as we have seen it develop under the voluntary plans which are currently in operation, is a good method of budgeting against the costs of medical services. We favor, and have had considerable experience with, plans developed under our own auspices which are characterized by a comprehensive range of benefits providing for the services of doctors in office, home and hospital. We believe that the large majority of our fellow citizens should be encouraged, as individuals, or as members of groups, to cover themselves with medical services insurance.

We recognize that three identifiable segments of the population are unable to do so under present circumstances and we believe that public funds should be provided selectively to subsidize the following:



hospital beds are required. The renovation of obsolete accommodation in many of our older general hospitals is also a foreseeable need. We estimate that capital expenditures, provided partly under the Hospital Construction Grant, will be approximately as follows:

1500 Active treatment beds	\$24,000,000
Renovation of obsolete institutions	\$10,000,000

Medical Services Insurance

In assessing the health needs of our province we place in fourth priority the expansion of medical services insurance to make benefits available to all residents. After a great deal of study of this matter it is considered opinion of the College of Physicians and Surgeons of Saskatchewan that medical services insurance as we have seen it developed under the voluntary plan which are currently in operation, is a good method of financing against the costs of medical services. We favor, and have had considerable experience with, plans developed under our own auspices which are characterized by a comprehensive range of benefits providing for the services of doctors, office, home and hospital. We believe that the large majority of our fellow citizens should be encouraged, as individuals, or as members of groups, to cover themselves. We recognize that these identifiable segments of the population are unable to do so under present circumstances and we believe that public funds should be provided selectively to subsidize the following:



- i) Those persons of all ages with low income and limited means;
- ii) Those persons over 65 years of age, whose premiums require subsidy in order to bring the premium for the coverage down to that applicable to persons under 65 years of age.
- iii) Those who cannot be insured at regular rates because of pre-existing medical conditions.

We estimate that the cost of subsidizing the above mentioned groups would cost from \$2.5 million to \$3.5 million, depending largely on the level established for financial assistance to the needy. Inherent in our proposal is the approval of carriers, able to administer a comprehensive service plan, and eligible to receive public funds in the form of subsidy.

Rehabilitation

The provision of accommodation for the convalescent and the chronically ill is closely related in our minds with the process of rehabilitation. Without active, organized effort to restore patients to their optimum capacity, the best of facilities will provide little more than custodial care. The three existing Physical Restoration Centres and the physical therapy departments of the larger general hospitals of the province provide the elements of a good program but in each instance, efforts are handicapped by lack of space and equipment and particularly by a shortage of personnel of all categories trained in medical and physical rehabilitation. We have spelled out in the narrative of our submission a plan whereby medical rehabilitation services may be implemented within the hospital system inducing the hoped for accommodation for long stay patients.



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We acknowledge the essential aid of the voluntary organization in the Co-ordinating Council on Rehabilitation and their efforts at financing from their own resources many worthy activities. We estimate that rehabilitation services within the context of the hospitals of Saskatchewan should be further supported by the expenditure of \$2,000,000 over the next five years for extension of services and that estimated annual maintenance expansion of \$500,000 be considered as hospital costs.

Detection of Visual and Auditory Impairment

A largely neglected area of preventive medical service relates to the early detection of visual defects and impairment of hearing among pre-school and school children. Mass screening procedures are available by which children suffering from either defect may be detected and referred for individual attention by appropriate specialist. It is considered desirable that selected public health nurses be trained in screening techniques and the use of the equipment. Such personnel should be designed as travelling teams to visit the schools of the province on a regular schedule, arranged to ensure that every child is examined not later than Grade 3. It is estimated that the cost of such a service would involve a capital outlay of \$50,000. for equipment and an annual expenditure of \$50,000 to maintain the service.

Mr. Chairman, before concluding the presentation of this summary I have been asked to call to your particular attention pages 28 to 33 of our submission and these are concerning the minority report, a memorandum of its own which is part of an interim report of the

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Mr. Chairman, before concluding the presentation of this summary I have been asked to call to your particular attention pages 28 to 33 of our submission and these are concerning the minority report, a memorandum of its own which is part of an interim report of the



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4 advisory committee on medical care. For your convenience
5 we wish to file a copy of this report with your secretary
6 as an exhibit.

7 Spokesmen for the College of Physicians and
8 Surgeons of Saskatchewan who have expert knowledge of
9 the fields touched upon in this submission will be glad to
10 elaborate for the information of the members of the
11 Royal Commission on Health Services.

12 THE CHAIRMAN: Thank you, Dr. Smith-Windsor.
13 What document is that you are filing?

14 DR. SMITH-WINDSOR: A copy of the minority
15 report which is included in our submission but it was
16 thought that for the convenience of the Commission --

17 THE CHAIRMAN: We already have it as part of
18 the minority report and also your submission so I think
19 we will not need to add to the record by filing an identical
20 document. Dr. Dalglish, is there any other observation
21 or statement which the College proposed to make this
22 morning at this time?

23 DR. DALGLISH: Mr. Chairman, we have nothing
24 further to state at this time and we will try with the
25 assistance of the doctors here with me to answer any
26 questions that the Commissioners may wish to ask of us.

27 There is one small point, we were glad to be
28 able to file a new printed version of our brief which I
29 believe has been presented to you. We are pleased to
30 note that the small size of this brief compared with other
documents which we filed with you which included our
original submission to the Thompson Committee a year ago
and which has been mentioned, the supplementary report.

advisory committee on medical care.

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the fields touched upon in this submission will be glad to

assist for the information of the members of the

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What document is that you are filing?

MR. SMITH: A copy of the minority

report which is included in our submission but it was

thought best for the convenience of the Commission --

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the minority report and also your submission so I think

we will not need to add to the record by filing an additional

document. Dr. Dainton, is there any other observation

on statement which the College proposed to make this

morning at this time?

DR. DAINTON: Mr. Chairman, we have nothing

further to state at this time and we will try with the

assistance of the doctors here with me to answer any

questions that the Commissioners may wish to ask of us.

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able to file a new printed version of our brief which I

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documents which we filed with you which included our



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3 THE CHAIRMAN: Which one are you referring to,
4 this one?

5 DR. DALGLEISH: Yes.

6 DR. BAROOTES: I think he is referring to the
7 fact that this foolscap document is now in print in a
8 summary booklet form and we were happy to make it avail-
9 able to you.

10 THE CHAIRMAN: I do not appear to have re-
11 ceived it yet.

12 DR. ANDERSON: To facilitate your carrying it
13 around.

14 THE CHAIRMAN: We might use those; we are all
15 working from the same page sequence.

16 DR. DALGLEISH: Mr. Chairman, we are still
17 using, as probably many of the Commissioners are, the
18 original copy.

19 THE CHAIRMAN: Thank you very much. Dr.
20 Dalgleish, Dr. Smith-Windsor, in reading the summary
21 dealt with one phase of a request which we sort of broad-
22 cast to everyone who will be making submissions and that
23 is that anyone coming forward with the suggestion or
24 additions of new programmes shall attempt to estimate
25 costs and you have done that. Are you in a position to
26 give us any assistance of the second aspect of our re-
27 quest, namely, with respect to where the money is to
28 come from? We appreciate in several of the recommendations
29 you have made there is quite a few millions of dollars
30 recommended initially for capital expense and a very
large figure for current, that would be operating ex-
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penses. Have you any views to express on where the



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4 money should come from for the projects that you
5 recommend?

6 DR. DALGLEISH: Mr. Chairman, specifically we
7 are not recommending any forms of taxation, or money
8 matters in that respect. However, we have tried to lay
9 out the health needs of the people of Saskatchewan, and
10 portray the places that we believe public funds should
11 be used to extend the urgent health needs of the people
12 of Saskatchewan in the areas of priority, and beyond that
13 we have not suggested where these funds be obtained.

14 THE CHAIRMAN: You can appreciate that the
15 source of funds is naturally a matter of concern to
16 Government, and Government is expecting some help from
17 this Commission. Now, I know you are not able, we would
18 not expect you to do it today, but is the College of
19 Physicians and Surgeons of Saskatchewan willing to give
20 the matter consideration, and to submit at a later time
21 its views on where the money should come from, Federally,
22 Provincially, Municipally, by way of taxation, by what-
23 ever form, and what kind of taxation?

24 DR. DALGLEISH: Well, Mr. Chairman, if you
25 feel that it would be of value to the studies of this
26 Commission, we would do our best to submit such cost
27 estimates. We don't consider ourselves as approaching
28 experts in that field in any sense.

29 THE CHAIRMAN: Well, perhaps experts may be
30 available on a fee-for-service basis then?

DR. ANDERSON: Mr. Chairman, I think though
that there is a realization that much of the programmes
that we feel have priority lie in the field where tax



dollars are concerned.

THE CHAIRMAN: That is the field that we are concerned about. Having regard to programmes that are in being, and projected, do you visualize that there is enough money to go, or not?

DR. ANDERSON: Sir, this is one of our fears, and among the fears of those concerned in other fields, such as the mental programme and the rehabilitation programme.

THE CHAIRMAN: You have mentioned those programmes. What about retarded children, and crippled children, and many other phases of illnesses and conditions?

DR. DALGLEISH: Mr. Chairman, we included in our discussion the mental health services, the centers that are used now for retarded children, namely in Moose Jaw and in Prince Albert, and we have included in the programme suggested as the aged and chronically ill, those people who you refer to with physical handicaps of a large proportion.

THE CHAIRMAN: So are you trying to say this, that your first priority includes all those categories, while you actually call it a priority of mental health?

DR. DALGLEISH: Yes, we do believe, Mr. Chairman, that the mental health programme would be no. 1 priority, and close to it would be the programme for the aged and the chronically ill.

DR. BAROOTES: Mr. Chairman, I believe our mental health programme, on which perhaps Dr. Lawson can elaborate further, it has been recommended by the College and the Saskatchewan Society of Psychiatrists,

dollars are concerned.

THE CHAIRMAN: That is the field that we are

concerned about. Having regard to programmes that are

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DR. DABOLICH: Mr. Chairman, we included in

our discussion the mental health services, the centres

that are used now for retarded children, mostly in Mexico

and in Puerto Rico, and we have included in the

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DR. DABOLICH: Yes, we do believe, Mr.

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DR. ANDERSON: Mr. Chairman, I believe our

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3 and by the Mental Health Association in their corroborative
4 evidence this morning and their support in its mental
5 health aspect does include congenital mental health and
6 retarded in its outline.

7 THE CHAIRMAN: Perhaps, Dr. Lawson, you might
8 if you wish expand on what is involved in this so-called
9 Saskatchewan Plan. That is a name that has been in ex-
10 istence now for a few years I believe?

11 DR. LAWSON: Mr. Chairman, the Saskatchewan
12 Plan is a plan for this Province that was promulgated
13 about seven years ago, and which we have been urging the
14 acceptance of since that time. The principles behind
15 this are not ours. They are pretty widely accepted
16 throughout the civilized world.

17 THE CHAIRMAN: Now, just initially is that
18 plan in writing? I mean, is there a document that contains
19 the essence of the plan, and explanations of it?

20 DR. LAWSON: There is, Mr. Chairman. As an
21 appendix to the submission of the Saskatchewan Psychia-
22 tric Association, which has requested an opportunity to
23 present a brief.

24 THE CHAIRMAN: That would be forthcoming?

25 DR. LAWSON: This is outlined.

26 THE CHAIRMAN: And that is the document you
27 are now talking about, the plan as it is contained in
28 that document?

29 DR. LAWSON: Yes.

30 THE CHAIRMAN: Thank you.

DR. LAWSON: Because of this written sub-
mission, it won't necessarily be necessary, I take it, to

and by the Mental Health Association in their corroborative

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THE CHAIRMAN: Perhaps, Dr. Lawson, you might if you wish expand on what is involved in this so-called Saskatchewan plan. That is a name that has been in existence now for a few years I believe?

DR. LAWSON: Mr. Chairman, the Saskatchewan plan is a plan for this Province that was promulgated about seven years ago, and which we have been using the acceptance of since that time. The principles behind this are not new. They are pretty widely accepted throughout the civilized world.

THE CHAIRMAN: Now, just initially is that plan in itself? I mean, is there a document that contains the essence of the plan, and explanations of it?

DR. LAWSON: There is, Mr. Chairman. As an appendix to the publication of the Saskatchewan Psychiatric Association, which has requested an opportunity to present a paper.

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THE CHAIRMAN: Thank you.

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4 go into detail.

5 The principles are as were mentioned by the
6 C.M.H.A. in their brief this morning, that the care of
7 the mentally ill should be transferred from the distant,
8 custodial type structure, which our mental hospitals are,
9 to a situation where the psychiatric patient, like the
10 physically ill patient, could receive his care in his
11 own community, so that there would be a possibility of
12 his retaining his place in his family by means of visits
13 both ways. The patient could go home for week-ends. The
relatives could come frequently to visit this individual.

14 The former concept was that once you were
15 mentally ill, you were always mentally ill, and they
16 talked of the patient being put away. In that case there
17 was no point in having the hospital custodial institution
18 anywhere near the home. Since the war particularly there
19 has been a great change in the attitude of psychiatrists
20 and of people who are interested generally, in their
21 thinking about mental illness. We have come to realize
22 that the mentally ill recover to the same extent, and as
23 often, as the individual with a heart condition, or other
24 physical disability, so we feel that it is important that
25 the facilities for the care of the mentally ill should
26 be in the same relation to the population they serve as
27 the general hospitals are. That the standards of care
should approximate, or be as good as that accorded to
the physically ill.

28 The Association of the Psychiatric Institution
29 called a general hospital is an important item in this
30 plan, in order that the segregation of psychiatric illness



go into detail.

The principles are as were mentioned by the C.M.H.A. in their brief this morning, that the care of the mentally ill should be transferred from the distant, to a situation where the psychiatric patient, like the physically ill patient, could receive his care in his own community, so that there would be a possibility of his retaining his place in his family by means of visits both ways. The patient could go home for week-ends, his relatives could come frequently to visit this individual. The former concept was that once you were mentally ill, you were always mentally ill, and they talked of the patient being put away. In that case there was no point in having the hospital custodial institution anywhere near the home. Since the way particularly there has been a great change in the attitude of psychiatrists and of people who are interested generally, in their thinking about mental illness. We have come to realize that the mentally ill recover to the same extent, and as often, as the individual with a heart condition, or other physical disability, so we feel that it is important that the facilities for the care of the mentally ill should be in the same relation to the population they serve as the general hospitals are. That the standards of care should approximate, or be as good as that accorded to the physically ill.

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3 and psychiatric personnel should cease. It provides
4 advantages both ways, I think. Psychiatric consultation
5 would be available to the general hospital, and various
6 types of consultation for the patient who is suffering
7 principally from a psychiatric disability, but may also
8 have other disabilities, can be obtained readily.

9 The question of how this should be located
10 is a moot one. As the C.M.H.A. also mentioned, some of
11 us think that a separate building or unit, physically
12 attached to the general hospital, is preferable to a
13 smaller ward incorporated right within the hospital.
14 These are very similar ideas, and it depends largely on
15 the size and shape of the building that is used for the
16 psychiatric patient. It is unlikely --

17 THE CHAIRMAN: I mean, is that different from
18 say, the presence of the Munroe Wing in the Regina General
19 here?

20 DR. LAWSON: No, that is right. The Munroe
21 Wing has a bed capacity of 30 odd, and we feel that it
22 would be advisable to have a large enough unit --

23 THE CHAIRMAN: But regardless of size, I mean
24 is that the idea, that it would be located on the grounds,
25 similarly as the Munroe Wing is?

26 DR. LAWSON: Yes. The proposed plan at
27 Yorkton, which has received architectural attention and
28 so on, envisages the attachment to the Yorkton Union
29 Hospital by a physical access in the form of a tunnel
30 connecting the basements, and an above-ground connection
from the general hospital. The difference, as I say,
between a psychiatric ward actually incorporated within
the hospital, and a separate building, is perhaps a minor



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and psychiatric personnel should cease. It provides advantages both ways, I think. Psychiatric consultation would be available to the general hospital, and various types of consultation for the patient who is suffering principally from a psychiatric disability, but may also have other disabilities, can be obtained readily.

The question of how this should be located is a moot one. As the C.M.H.A. also mentioned, some of us think that a separate building or unit, or possibly attached to the general hospital, is preferable to a smaller ward incorporated into the hospital. These are very similar ideas, and it depends largely on the size and shape of the building that is used for the psychiatric patient. It is difficult --

THE CHAIRMAN: I mean, is that different from say, the presence of the Nurses' Wing in the building for the hospital?

DR. LAWSON: No, that is right. The Nurses' Wing has a bed capacity of 30 odd, and we feel that it would be advisable to have a large enough unit --

THE CHAIRMAN: But regardless of size, I mean, is that the idea?

DR. LAWSON: Yes. The proposed plan is similar to the Nurses' Wing, is it?

DR. LAWSON: Yes. The proposed plan is similar to the Nurses' Wing, which has received architectural attention and so on, and lays the attachment to the Nurses' Wing Hospital by a physical access in the form of a tunnel.



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3 difference, except on one point, and that is that we feel
4 that if we have too small a psychiatric unit attached
5 right within the general hospital, then it will neces-
6 sitate some other type of accommodation for ones that
7 cannot be accommodated at this one place, and this is
8 what has happened to date.

9 The Munroe Wing is quite a respectable place
10 to go, not quite as respectable as the medical or surgi-
11 cal ward, but the mental hospital at Weyburn is a place
12 where the crazy people go. There is this dichotomy between
13 the distant mental hospital and the psychiatric ward or
unit, right close to the hospital.

14 If we can avoid that, I think we have gained
15 something. There is some physical structure that can be
16 incorporated in a separate building, that perhaps is going
17 to be difficult to incorporate in the psychiatric ward,
18 which will follow the general pattern of the medical and
19 surgical wards. We feel that some people feel that there
20 is an advantage to being able to arrange your facilities
21 within the building a little bit differently than those
provided for the medical or surgical patient.

22 THE CHAIRMAN: Now, those are the basic ele-
23 ments of the Saskatchewan Plan?

24 DR. LAWSON: That is right, sir.

25 THE CHAIRMAN: Did that plan receive govern-
26 mental approval?

27 DR. LAWSON: No. The plan as such has not
28 received approval anywhere, though some of the features
of it have been approved elsewhere.

29 THE CHAIRMAN: By elsewhere, do you mean
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3 outside of Saskatchewan?

4 DR. LAWSON: Elsewhere in Canada.

5 THE CHAIRMAN: Where for instance?

6 DR. LAWSON: There is an adaptation of it in
7 Ontario and in Nova Scotia. Many of the principles are
8 involved in these two ideas. They are not identical.
9 The Saskatchewan Plan is for Saskatchewan. It is specific
10 for Saskatchewan. The principles are universal.

11 THE CHAIRMAN: And this projected ward at
12 Yorkton would be in harmony with the plan, if proceeded
13 with?

14 DR. LAWSON: Yes, if it is proceeded with, it
15 would be the first unit of the plan, but there has been
16 no actual acceptance of the plan as such with the creation
17 of other units.

18 DR. BAROOTES: I think, sir, it would be fair
19 to add though, that it would be our feeling as physicians
20 that the Saskatchewan Plan principle has been accepted
21 by our Government. Would that be correct, Dr. Lawson,
22 that in principle it must have been accepted? I think
23 this has been said, and I think that the unit in Yorkton
24 is the first overt application of accepting the principle.

25 DR. LAWSON: There has been no actual state-
26 ment that this is a plan which will be gone ahead with.
27 The principles are perhaps accepted in varying degrees
28 by different people in the Government.

29 THE CHAIRMAN: Now, but Yorkton I suppose be-
30 came feasible because there was the building of a new
hospital, the Yorkton Union Hospital?

DR. LAWSON: That assisted in it being located



outside of Saskatchewan?

Anywhere in Canada.

DR. LAWSON: There is an adaptation of it in Ontario and in Nova Scotia, many of the principles are involved in these two ideas. They are not identical. The Saskatchewan Plan is for Saskatchewan. It is similar.

THE CHAIRMAN: And this projected ward at

DR. LAWSON: Yes, if it is proceeded with, it

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came feasible because there was the building of a new hospital, the Yorkton Union Hospital?



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3 there. We had asked for anywhere, hoping for the first
4 one to be in a rural area, rather than in one of
5 the large cities.

6 THE CHAIRMAN: Would the direction, that is the
7 bringing into being of a similar ward, be facilitated in
8 connection with the building of new hospitals, rather
9 than attaching it to existing hospitals? In the over-all
10 will it work out better if in building a new hospital you
11 also see the psychiatric ward attached?

12 DR. LAWSON: Yes, sir.

13 THE CHAIRMAN: And I think there is a new
14 hospital being built at Saskatoon, I think, as you may
15 know, Dr. Lawson?

16 DR. LAWSON: Yes.

17 THE CHAIRMAN: Were there representations made
18 by the Saskatoon Board of Trade, or Chamber of Commerce,
19 or whatever they call themselves, and the Saskatoon
20 Medical Association, to have a similar ward as was being
21 projected for Yorkton attached to the new St. Paul's
22 Hospital in Saskatoon?

23 DR. LAWSON: I believe there were.

24 THE CHAIRMAN: And with what result?

25 DR. LAWSON: I don't know. It was not made
26 to me directly. It would be made to the Department or
27 the Minister, though I understand they were going to do
28 it.

29 COMMISSIONER McCUTCHEON: Nothing has been
30 done to date?

DR. LAWSON: Not as far as I know.

DR. BAROOTES: So, I might add that in the



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the large cities.

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will it work out better if we building a new hospital you

also see the psychiatric ward attached?

DR. LAYTON: Yes, sir.

THE CHAIRMAN: And I think there is a new

hospital being built at Guelph, I think, as you say

DR. LAYTON: Yes.

THE CHAIRMAN: Now, where would these hospitals be?

by the Guelph Board of Trade, or Chamber of Commerce,

or whatever they call themselves, and the Guelph

Medical Association, to have a similar ward at the new

hospital you talked attached to the new St. Paul's

hospital in Guelph?

DR. LAYTON: I believe there were.

THE CHAIRMAN: And with what results?

DR. LAYTON: I don't know. It was not made

to me directly. It would be made to the department of

the Minister, though, I understand they were going to do

DR. LAYTON: Not as far as I know.

DR. HANCOCK: So, I think that in the



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4 renovation that is hoped for and planned for in our
5 large general hospital in Regina, the Regina General
6 Hospital, one of the projections is to include one of
7 the large wings, as perhaps either a progressive care
8 unit, or as a mental health unit, attached to the hospi-
9 tal either physically or directly by a tunnel. The big
10 saving of course is in mental services, as you must
11 realize, and also in many ways, such as personnel services.
12 We would not feel as a College of Physicians and Surgeons,
13 that in our present state of economy in Saskatchewan,
14 that it would be feasible to build eleven such units.
15 You will notice our estimate, which is an estimate which
16 has been attained by very close attention, it is not a
17 guesstimate, it is a very actual estimate, of 20 some odd
18 million dollars for capital cost, and then subsequently
19 a rising of the average annual cost from what was originally
20 about 10 million to about 20 million. We would not en-
21 visage that this Province, in its potential, would find
22 it feasible to do this in one fell swoop, overnight. We
23 would like to see what we call the co-operative, co-
24 ordinated effort by our Government, psychiatrists, econo-
25 mists and so forth, and do this gradually without dis-
26 ruption of other services, but bearing in mind that the
27 ultimate operation cost would be double of what our present
28 operation cost is.

29 COMMISSIONER McCUTCHEON: That is what happens
30 when you bring the level of care to the mentally ill up
to that that you give to the physically ill, even though
it might not cost as much for the mentally ill, but the same
standard of care?



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3 DR. BAROOTES: That is right, sir. We have
4 actual working papers on this, which may be of interest
5 to your research staff, which we may be able to provide,
6 but there may be difficulty as they are in the hands of
7 the people who prepared them for us.

8 THE CHAIRMAN: As a matter of cost, has the
9 College of Physicians and Surgeons a view on whether
10 costs of mental illnesses and also of tuberculosis should
11 be sharable costs under the hospitalization plan?

12 DR. BAROOTES: We have so stated, sir, in our
13 brief too.

14 THE CHAIRMAN: That is your view? You stated
15 as to mental. Does it also include tuberculosis in it?

16 DR. BAROOTES: We make no pronouncement in
17 regard to tuberculosis. As elsewhere in Canada, it may
18 be a diminishing item. When you are asking about costs,
19 and asking us to give perhaps suggestions, and I hate to
20 bring this up, about where the sources of revenue should
21 be, may we take another look at this with you in the dis-
22 cussion. We have estimated some costs to you as accurately
23 as we could. Some of them are well-founded. Some of them
24 are not quite as well estimated, and I am sure that men
25 like yourselves would be able to look at them more care-
26 fully with us.

27 But then, you asked us as to the source of
28 this revenue. There are two points that come to our mind
29 in this regard. The first one is that in a society such
30 as ours, one wishes to meet needs in the ratio of prior-
ities, and in our submission to you we would like you to
consider that if this Province, or if we as a people



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4 collectively feel that we can supply some 20 to 25 mil-
5 lion dollars out of our taxation potential, to provide
6 a good care, or increasingly good care, or the same level
7 of care as many of us self-sufficient people are now re-
8 ceiving, and if we are able to raise this tax potential,
there are two worries that come to our mind.

Y/je 9 The first is that we should not provide for
10 everyone something for which we are already providing for
11 ourselves out of our own resources; in other words,
12 giving ourselves a bonus. But, to provide some portion
13 of these monies, to people and groups of society and
14 groups of patients whom we have found to be less fortu-
15 nate than ourselves, and be able to give them assistance
16 in depth; not to give them the same assistance we are
17 giving to ourselves, because when you give a universal
18 handout, the rich and poor and the fortunate and un-
19 fortunate alike get the same assistance, and really the
20 person who requires the assistance gets no priority. If
21 this Province can raise \$25 million for the sake of a
22 programme for many of us who are able to provide for
23 ourselves, we would think the transferability of some of
24 that potential of taxation to some of those more urgent
25 needs and to the less fortunate people would be one hope.

26 The other aspect of this very same thing that
27 bothers some of us a little bit is, should we take the
28 taxation potential and tax ourselves for \$25 million for
29 all of us, who seem to be enjoying a relatively good
30 degree of health and standard of living, then would this
exhaust our tax potential for these other needed pro-
grammes. Would it freeze us at this level so we could
not perhaps undertake the modality of improvement we



collectively feel that we can supply some 20 to 25 million dollars out of our taxation potential, to provide a good case, or interestingly, good case, or the same level of case as many of us self-sufficient people are now receiving, and if we are able to raise this tax potential, there are two worries that come to our mind.

The first is that we should not provide for everyone something for which we are already providing for ourselves out of our own resources; in other words, giving ourselves a bonus. But, to provide some portion of these monies, to people and some of society and groups of patients whom we have loaned to us last for a rate than ourselves, and to give them that assistance in depth; not to give them the same assistance we are giving to ourselves, because when you give a universal grant, the rich and poor and the fortunate and unfortunate alike get the same assistance, and really the person who requires the assistance gets no priority. If this program can raise \$25 million for the sake of a program for any of us who are able to provide for ourselves, we would think the responsibility of some of that potential of taxation to some of those more urgent needs and to the less fortunate people would be one hope. The other aspect of this very same thing that

bothers some of us a little bit is, should we take the taxation potential and tax ourselves for \$25 million, or all of us, who seem to be enjoying a relatively good degree of health and standard of living, then would this program, would it freeze us at this level as we could not perhaps undertake the mobility of improvement we



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3 have found -- mental health, aged care, rehabilitation
4 etcetera -- for the low income groups. This was the
5 aspect that occurred to us. Not being experts in tax-
6 ation problems -- and I realize some of you on your
7 Commission are, and perhaps some others here at our table
8 -- we are like the specialist, and if I may give you an
9 example in parody which was told to me by, I believe, one
10 of your own group. We are not experts in the matters of
11 raising taxation. I realize the gentleman who sat head-
12 ing the delegation yesterday is, and I realize Commission-
13 er Firestone must be and others, but we are like the
14 amateur specialist who likes to guess at these things,
15 but his opinion may not be as valuable to you as the
16 opinion of others.

16 The parody is the man who was an expert in
17 piscatorial work, and he was asked by a friend of his
18 who had two goldfish, one of which was a male and the
19 other a female: "My two children, one a boy and the other
20 a girl, love to feed these goldfish, and we have a ter-
21 rible time because the boy wants to feed the male and
22 the girl wants to feed the female. How do I know which
23 is the male and which is the female?" He replied, "It
24 is very simple: all you have to do is go outside and
25 get a female earthworm and give it to the girl and she
26 can drop it in, and give a male earthworm to the boy."
27 "That is wonderful, he said." but a minute later it
28 dawned on him and he said, "I am terribly sorry, but
29 how can I tell a female earthworm from a male earthworm?"
30 and the reply was, "Oh, I am a specialist in piscatorial
work. Go and talk to an etymologist who is a specialist



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aspect that occurred to us. Not being experts in tax-
ation problems -- and I realize some of you are
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-- we are like the specialist, and if I may give you an
example in parody which was told to me by, I believe, one
of your own group. We are not experts in the matter of
raising taxation. I realize the man said he was not
in the delegation yesterday, and I realize something
or something must be and others, but we are like the
amateur, a specialist who likes to guess at these things.
But his opinion may not be as valuable to you as the
opinion of others.

The parody is the man who was an expert in
scientific work, and he was asked by a friend of his
who had two children, one of which was a girl and the
other a female: "Why two children, one a boy and the other
a girl, love to read these Golden, and we have a lot
right time because the boy wants to feed the female, how do I know which
the girl wants to feed the female? He said, "It
is the male and which is the female?" He said, "It
is very simple: all you have to do is go outside and
let a female cat scratch and give it to the girl and she
can drop it in, and give a male cat scratch and he
"It is wonderful," he said. "But I realize that is
based on his and he said, "I am not a specialist, but
how can I tell a female cat scratch and give it to the girl
and the boy was, "Oh, I am a specialist in this
book. He said to me in a lecture and he said,



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4 in worms."

5 THE CHAIRMAN: Dr. Dalglish, the health situ-
6 ation in Saskatchewan was investigated by the Advisory
7 Planning Committee -- that is, the Thompson Committee:
8 did that Committee have anything to say or to offer in
9 terms of this situation of mental health as a priority
or as deserving of priority?

10 DR. DALGLISH: To my knowledge there has been
11 no recommendation come forth at the present time.

12 THE CHAIRMAN: I would like to draw your at-
13 tention to pages 21 and the table on page 23 of the in-
14 terim report. It is in the special diseases services,
15 section E, sub-title "Mental Health". Table 2 is part
16 of it, where it says, "The most important special social
17 service operating in the Province relates to the in-
18 stitutional care of the mentally ill and mentally re-
tarded...", and so forth.

19 The next paragraph: "Further study in this
20 area is being planned by the Committee in consultation
21 with the Psychiatric Services Branch of the Department
22 of Public Health, University authorities and others.
23 We (that is, the Committee) intend to make specific
24 recommendations in our final report concerning (a) means
25 to improve standards of care, (b) extension of both in-
26 stitutional and community facilities, and (c) the pos-
sibilities inherent in the use of local physicians..."
and so forth.

27 Then: "The Committee wishes to record its
28 concern with the slow progress being made in implement-
29 ing the so-called 'Saskatchewan Plan' of community mental
30

in women."

THE CHAIRMAN: Dr. Dalziel, the health situation in Saskatchewan was investigated by the Advisory Planning Committee -- that is, the Thompson Committee; did that Committee have anything to say or to offer in terms of this situation of mental health as a priority or as deserving of priority?

DR. DALZIEL: To my knowledge there has been no recommendation come forth at the present time.

THE CHAIRMAN: I would like to draw your attention to pages 21 and the table on page 23 of the interim report. It is in the special diseases services, section E, sub-title "Mental Health". Table 2 is part of it, where it says, "The most important special social service operating in the Province relates to the institutional care of the mentally ill and mentally retarded..." and so forth.

The next paragraph: "Further study in this area is being planned by the Committee in consultation with the Psychiatric Services Branch of the Department of Public Health, University authorities and others. We (that is, the Committee) intend to make specific recommendations in our final report concerning (a) means to improve standards of care, (b) extension of both institutional and community facilities, and (c) the possibilities inherent in the use of local physicians..." and so forth.

Then: "The Committee wishes to record its concern with the slow progress being made in implementing the so-called 'Saskatchewan Plan' of community mental



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3 health facilities, and hopes that the Government will in-
4 crease its efforts in this regard as a matter of the
5 highest priority."

6 How does that statement harmonize with the
7 views of the College of Physicians and Surgeons of
8 Saskatchewan?

9 DR. BAROOTES: Mr. Chairman, as you elaborated
10 in your discussions, I believe, this morning, we had
11 hoped in the Thompson Committee to make a study of all
12 health needs, to grade them and give priorities and
13 consider costs, but owing to the anxiety to have an in-
14 terim report based on physicians' services only, the
15 Committee which had undertaken studies in all these fields
16 concurrently, as I am sure your research staff is doing
17 with you, found it necessary to concentrate our efforts
18 essentially on the physicians' services aspect for the
19 interim report from which you read. However, we felt it
20 proper to at least mention that we had noted considerable
21 deficiencies in certain other aspects of a health pro-
22 gramme, and that we would study it further once we had
23 completed the report which was requested by the Minister.
24 We have undertaken this. These consultations with the
25 psychiatric services branch, with the University author-
26 ities and others interested in the subject have pro-
27 ceeded, and are not as yet completely finalized. In the
28 final report of the Thompson Committee one would hope --

29 THE CHAIRMAN: Well, I am not asking you to
30 anticipate the report.

31 DR. BAROOTES: But I say they are virtually
32 completed and one would hope in the not too distant



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ities and others interested in the subject have pro-
ceeded, and are not yet completely finalized. In the
final report of the Thompson Committee one would hope --
THE CHAIRMAN: Well, I am not asking you to
anticipate the report.
DR. PARSONS: But I say they are virtually
completed and one would hope in the not too distant



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4 future they will be forthcoming, and I think one would
5 say that this general recommendation embracing our hope
6 that the Government would give some consideration, and to
7 reserve some of this potential strength in this field,
8 we hope, has been taken to heart and that they will be
9 able to implement some of the recommendations. They are
10 fairly good recommendations, we believe. They haven't
11 been completely finalized.

12 THE CHAIRMAN: Was there any dissent in the
13 interim report as to this statement that the Committee
14 hopes that the Government will increase its efforts in
15 this regard as a matter of highest priority?

16 DR. ANDERSON: No. I think I might point out,
17 Mr. Chairman, that in Chapter VI of the same report the
18 Committee states: "The time available to the Committee
19 to date has not permitted a full scale study of the mental
20 health programme and the Committee is not prepared at this
21 time to put forward detailed recommendations regarding
22 psychiatric care and its relationship to a medical care
23 insurance programme." So, there was no consideration of
24 the real priority.

25 "The Committee recommends therefore that the
26 Government of Saskatchewan take into account in their
27 financial planning the need for a considerable increase
28 in expenditure in the mental health field."

29 "The Committee will deal with this matter more
30 fully in its final report..."

DR. BAROOTES: The minority signers also agreed.

THE CHAIRMAN: Whether the minority signers or
the dissenting --

future they will be forthcoming, and I think one would say that this general recommendation embracing our hope that the Government would give some consideration, and to reserve some of this potential strength in this field, we hope, has been taken to heart and that they will be able to implement some of the recommendations. They are fairly good recommendations, we believe. They haven't been completely finalized.

THE CHAIRMAN: Was there any dissent in the interim report as to this statement that the Committee hopes that the Government will increase its efforts in this regard as a matter of a first priority?

MR. ANDERSON: No. I think I might point out, Mr. Chairman, that in Chapter II of the same report the Committee stated: "The time available to the Committee to date has not permitted a full scale study of the mental health programme and the Committee is not prepared at this time to put forward detailed recommendations regarding psychiatric care and its relationship to a medical care insurance programme." So, there was no consideration of the need priority.

"The Committee recommends therefore that the Government of Saskatchewan take the action in the financial planning the need for a considerably increase in expenditure in the mental health field."

"The Committee will deal with this matter more fully in its final report..."

DR. BARTON: The minority signers also agreed

THE CHAIRMAN: Whether the minority signers or

the dissenting --



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3 DR. BAROOTES: The five who signed the minority
4 reports or dissenting memoranda all feel the same way
5 about this, as the majority do.

6 THE CHAIRMAN: I can read the report and get
7 the answer, but maybe you could tell me: Mr. Smishek
8 dissented from this; he had a dissenting report which was
9 additional to the sub report.

10 DR. ANDERSON: I think it would be fair to
11 say there may have been varying views in the Committee
12 as priorities of need. Some of them, I think, would
13 have possibly put the programme for the payment of
14 doctors for their personal services above other matters.

15 DR. BAROOTES: My memory of this is not com-
16 plete. Mr. Sparkes could have answered it for you, but
17 I would think this section of the report was passed un-
18 animously.

19 COMMISSIONER BALTZAN: Gentlemen, in your sum-
20 mary and recommendations, was it your purpose to concen-
21 trate primarily on the deficiency areas in the existing
22 health services as against something of a broader nature?

23 DR. DALGLEISH: Mr. Chairman and Mr. Commis-
24 sioner, the answer to that is yes.

25 COMMISSIONER BALTZAN: You do so because you
26 feel that remedies in these connections take priority --
27 they are urgent in this Province?

28 DR. DALGLEISH: Mr. Commissioner, that is
29 correct. In studying the health needs of the people
30 these deficiencies stand out as very urgent needs, and
are considered ahead of medical service insurance.

COMMISSIONER BALTZAN: Dr. Dalglish, does it
follow that further progressive steps as they may be

DR. BAROOTS: The five who signed the minority

reports on dissenting memoranda all feel the same way

about this, as the majority do.

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the answer, but maybe you could tell me: Mr. Baroots,

dissented from this; he had a dissenting report which was

additional to the sub report.

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say there may have been varying views in the Committee

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DR. DABALISH: Mr. Commissioner, that is

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these deficiencies stand out as very urgent needs, and

are considered ahead of medical service insurance.

COMMISSIONER BALTIAN: Dr. Dabulich, does it

follow that further progressive steps as they may be



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3 evolving in time based on the best interests of the re-
4 cipients and providers of the health services -- you
5 would be ready to support, as you have in the past any-
6 thing that further develops in a progressive manner;
7 after completing these priority things you would go on?

8 DR. DALGLEISH: The answer is yes, in the ex-
9 perience that is gained in the intervening time.

10 COMMISSIONER BALTZAN: Yesterday the Minister
11 of Health questioned somewhat -- and I haven't got his
12 exact words -- but in referring to various voluntary
13 bodies, insuring agencies of a voluntary type, he
14 questioned their existence because -- I think I am right
15 in saying -- there wasn't public participation in these
16 organizations. May I ask you, is there public partici-

17 DR. DALGLEISH: Yes.

18 COMMISSIONER BALTZAN: There is?

19 DR. DALGLEISH: Yes.

20 COMMISSIONER BALTZAN: And would you say the
21 same about Group Medical Services in Regina?

22 DR. BAROOTES: This requires the affirmative
23 answer with an explanation.

24 COMMISSIONER BALTZAN: Please.

25 DR. BAROOTES: I heard the remarks made yester-
26 day and I am pleased this has been brought up again.
27 Group Medical Services in Regina consists of a Board in
28 which the subscribers elect from themselves half the
29 members of the Board. The doctors on the other hand
30 from their professional group elect half the members of
the Board, with the exception of one doctor member who is



evolving in time based on the best interests of the patients and members of the health services -- you would be ready to support, as you have in the past any-

after completing these priority things you would go on to...
 DR. BARON: The answer is yes, in the experience that is gained in the intervening time.

of health services somewhat -- and I haven't got the exact figure -- in referring to various voluntary bodies, I would estimate on a voluntary basis, the question of the existence of bodies -- I think I am right...
 DR. BARON: May I ask you, is it a voluntary organization?

DR. BARON: Yes.
 DR. BARON: Yes.
 DR. BARON: Yes.

COMMISSIONER BARTON: And would you say the same about Group Medical Services in Britain?
 DR. BARON: This requires the affirmative answer with an explanation.

DR. BARON: I hear the relative number of day and night staff has been brought up again. Group Medical Services in Britain consists of a body in which the subscribers elect from themselves half the members of the Board. The doctors on the other hand from their professional group elect half the members of the Board, with the exception of one doctor member who is



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4 appointed as a liaison from the College of Physicians
5 and Surgeons of Saskatchewan. Therefore, it is a purely
6 representative body of those both giving and those re-
7 ceiving services. They are elected by their own profes-
8 sional and subscriber bodies. Moreover, financially the
9 funds, the reserves, in this undertaking belong to both
10 bodies, and in case of wind-up belong to both bodies, or
11 in case of financial failure, as one time occurred before
12 this organization was formed. So that we underwrite it
13 jointly, although, of course, in times of financial hazard
14 the doctors really underwrite it. But, the Committees
15 upon which we sit in this scheme or in which people sit
16 are headed and made up chiefly in the same format, al-
17 though it is overweighted from the point of view of the
18 non-doctor representatives. The meetings are most heavily
19 attended and policy is set chiefly by those who attend
20 the meetings of the Board of Directors, which are the
21 non-doctor members, and it is a service plan. By that
22 we mean the doctors have contracted to give service to the
23 beneficiaries of this plan -- the doctors of the Province.
24 There is one other modality of it which is rather interest-
25 ing, and that is, as far as I am concerned -- and I have
26 been on the Board of this organization for a number of
27 years -- I do not recall to date one major item of dis-
28 agreement amongst the Board of this group, and as a repre-
29 sentative of the Trans-Canada Medical Plans, which is a
30 Federal body with these eleven organizations, I find no
disagreement between laity and professional people. We
work together.

There is one correction I must make in M.S.I.:

appointed as a liaison from the College of Physicians
and Surgeons of Saskatchewan. Therefore, it is a purely
representative body of those both living and those not
living overseas. They are elected by their own profes-
sional and corporate bodies. Moreover, financially the
funds, the reserves, in this undertaking belong to both
bodies, and in case of winding-up of both bodies, or
in case of financial failure, at the time occurred before
this organization was formed. So that we understand it
jointly, although, of course, it was at financial hazard
the doctors really undertake it. In the circumstances
upon which we sit in this scheme is in which people it
are headed and made up chiefly in two main parts, 21-
though it is overbalanced from the point of view of the
non-doctor members. The members are most heavily
attended and policy is set rather by those who attend
the meetings of the Joint of Directors, which are the
non-doctor members, and it is a service plan. By that
we mean the doctors have consented to give service to the
beneficiaries of this plan -- the doctors of the Province.
There is one other matter of it which is rather interest-
ing, and that is, as far as I am concerned -- and I have
been on the Board of this organization for a number of
years -- I do not recall to date one major item of dis-
agreement amongst the board of this group, and as a repre-
sentative of the Trans-Canada Medical Union, which is a
federal body with these eleven organizations, I find no
disagreement between lay and professional people. We
work together.



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3 The Board is virtually the same. The Board in M.S.I.
4 consists of doctors who are selected by their own dis-
5 trict medical societies; and from each geographical
6 district a lay representative is also on the Board.

cH/je 7 It is a 50/50 Board, it is a co-operative
8 Board, if the word is acceptable to you. Finally, on
9 both these organizations -- I am anticipating your
10 question -- there are Governmental representatives on the
11 Board of G.M.S. in the last eleven years. I might be
12 off a year or two but there have always been two senior
13 members of the Governmental service, usually men of
14 rather high range.

15 COMMISSIONER BALTZAN: What department?

16 DR. BAROOTES: Well the past Deputy Minister
17 I believe of Municipal Affairs has been a member -- Mr.
18 Walters --

19 COMMISSIONER BALTZAN: They came on as members
20 of the public and were not delegated to the Board by
21 Government?

22 DR. BAROOTES: That is right, they are dele-
23 gated by their subscription and we also have Municipal
24 Government representatives on both Boards, that is
25 Secretaries of municipalities and various officials.

26 THE CHAIRMAN: It may be more properly said
27 you have on the Board in the order of persons who also
28 hold municipal offices?

29 DR. BAROOTES: Yes, rather than say they repre-
30 sent the municipality.

THE CHAIRMAN: They are municipal repre-
sentatives?

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The Board is virtually the same. The Board in 1911, consists of persons who are selected by the community. It is a 100% Board, it is a co-operative Board, if the word is acceptable to you. Finally, of both these organizations -- I am attending your

Board of 1911, in the last few years, I might be off a year or two but there have always been two senior members of the Government service, usually one of rather high rank.

Mr. BARON: I believe of medical rank. I have a number of

of the public and were not before the Board by

Mr. BARON: That is right, they are designated of public subscription and we also have biological Government representatives on both boards, that is

THE CHAIRMAN: It may be more properly said you have on the Board in the order of persons who also

Mr. BARON: Yes, rather than any they represent the municipality.

THE CHAIRMAN: They are municipal representatives.



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3 DR. BAROOTES: That is right.

4 COMMISSIONER BALTZAN: Dr. Barootes, speaking
5 in the same connection, does the Saskatchewan Mutual
6 Hospital and Benefit Association still exist? Is it in
7 operation?

8 DR. BAROOTES: The Mutual --

9 COMMISSIONER BALTZAN: It is on page 22.

10 DR. BAROOTES: You mean the Medical Co-Op in
11 Saskatoon?

12 COMMISSIONER BALTZAN: Yes.

13 DR. BAROOTES: Yes, it is, sir.

14 COMMISSIONER BALTZAN: And is that a medical
15 organization or is that a lay organization?

16 DR. DALGLEISH: That is a lay organization.

17 COMMISSIONER BALTZAN: And it is still in
18 operation?

19 DR. DALGLEISH: Yes, sir.

20 DR. BAROOTES: Asking me that question is not
21 fair, you must realize my time and my age.

22 COMMISSIONER BALTZAN: In other words, the
23 answer is a little bit different from the impression that
24 was left yesterday that there is non-lay participation;
25 that is really what I was after.

26 DR. BAROOTES: I would hope it would be our
27 interpretation of how we check our Boards in case there
28 is a misinterpretation.

29 COMMISSIONER BALTZAN: I have before me this
30 note and also from your interim report reference is made
to a Commission and a medical advisory committee; is this
a novelty or have you had experience with other advisory

MR. BAROOTS: That is right.
COMMISSIONER BALTAN: Dr. Baroots, speaking
in the same connection, does the Saskatchewan Mutual
Hospital and Benefit Association still exist? Is it in
operation?

MR. BAROOTS: The Mutual --
COMMISSIONER BALTAN: It is on page 12.
MR. BAROOTS: You mean the Medical Co-Op in

MR. BAROOTS: Yes, it is, sir.
COMMISSIONER BALTAN: And is that a medical
organization or is that a lay organization?
MR. BAROOTS: That is a lay organization.
COMMISSIONER BALTAN: And it is still in

MR. BAROOTS: Yes, sir.
MR. BAROOTS: Asking me that question is not
fair, you must realize my time and my age.

COMMISSIONER BALTAN: In other words, the
answer is a little bit different from the impression that
was left yesterday that there is non-lay participation;
that is really what I was after.

MR. BAROOTS: I would hope it would be our
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to a Commission and a medical advisory committee; is this
a novelty or have you had experience with other advisory



councils on health services? Have you had experience on such bodies and what has your experience been?

DR. ANDERSON: I can answer that question because of past experience actually of the medical profession in this province in respect to health planning commissions and advisory committees to the Government and one in general that has failed to establish any feeling of real confidence in the ability of advisory bodies such as have been provided in the past, is their ability to really and truly be effective bodies in health matters. Now, I say that from the standpoint of the Health Services Act of 1944; Bill 58 provided for a health service planning commission. There were three members on that Commission, all members of the civil service. This provided for the setting up of an advisory committee to that health planning commission of 25 people which is similar to the body that is suggested in the Act, the new Act. That body held two meetings, one in March of 1944, the second meeting for advice on health matters which was urgent at the time in the Province. The second meeting was held 14 months later. In 1952 a new statutory body was set up in this Province called the Health Services Planning Commission of the Province. There were 15 members that were appointed to be the advisory to the Minister of Health. This was a representative committee which included two physicians named by the College and representatives of various other walks of life, the Rural Municipalities Association, the Urban Municipalities Association, a doctor, a nurse, and the Act provided for it to meet virtually five times a year or five times within a ten-



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4 month period of time. In the first three years it met
5 five times each year. In the successive years, in 1957
6 it met twice; in 1958 it had no meetings; in 1959 it met
7 four times and it has only met once since, in April of
8 1960. It has not met since although it has a sub-
9 committee that was set up in June of 1959 to conduct a
10 survey in the Saskatchewan Hospital Services which is
11 still functioning but has made, of course, no report to
12 its parent body.

13 Now, in spite of the chairman of this Health
14 Services Planning Commission being requested at its last
15 meeting to take steps to keep this Commission informed,
16 it was felt that this Health Services Commission should
17 be informed in regard to the studies that were being con-
18 ducted by the Study Committee on age and long-term illness
19 and the Thompson Committee. No reports were ever made
20 nor has that body been called into being. Furthermore,
21 I would indicate that this body that was supposed to be
22 and still is in existence, Health Services Planning
23 Commission, was not called upon to do the health planning
24 but the new committee, so-called Thompson Committee, was
25 set up. So, our experience with advisory committees is
26 not one that has inspired us with too much confidence.

27 COMMISSIONER BALTZAN: Thank you for your
28 detailed explanation. I want to turn for just one brief
29 moment to page 1 in connection with the history and you
30 went into that at great length. I must say I am very
grateful to you for the memories because it covers a good
period of my experience here. But, my question is, was
it your object in going on at length to show how health

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COMMISSIONER BATTAM: Thank you for your detailed explanation. I want to turn for just one brief moment to page 1 in connection with the history and you went into that at great length. I must say I am very grateful to you for the memories because it covers a good period of my experience here. But, my question is, was it your object in going on at length to show how health



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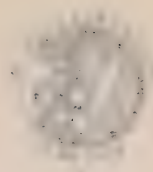
services and health conditions progressed in this Province according to the indigenous requirements or was it just to put it on the record?

DR. DALGLEISH: Well, Mr. Chairman, we had in mind the portraying, and not only because we are proud of those doctors that went before us, the programmes that were developed and encouraged and the interest taken by these pioneer doctors in the welfare of the citizens of the Province in establishing certain programmes. I think it also emphasizes, as you read it, how the services to the people have developed in a voluntary pattern, that we have had a variety of programmes that have evolved such as the municipal programme and so on. That has failed and we have had them as experiments and we have drawn conclusions from them and as they were of service during this time and many of them still are. It allows us to develop the programmes which we think are the best suited to our patients. In other words, evolution rather than revolution.

COMMISSIONER BALTZAN: Dr. Dalgleish, on page 6, Paragraph 17 the Medical Services Act was put into force in 1937 and five years later, 1942, the Act was repealed. My question is this, for information, and I should know but I do not; was this rescinding or repealing a spontaneous action on the part of Government or was there any appeal made or some outside pressure brought to bear to have the Act revised or rescinded?

DR. DALGLEISH: No, I think the need had disappeared and the Act was not needed.

COMMISSIONER BALTZAN: In other words, meeting



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services and health conditions progressed in this Province according to the indigenous requirements or was it just to put it on the records?

DR. DALVI: Well, Mr. Chairman, we had in mind the postwar, and not only because we are proud of those doctors that went before us, the programmes that were developed and encouraged and the interest taken by these pioneer doctors in the welfare of the citizens of the Province in establishing research programmes. I think it also emphasised, as you read it, how the services to the people have developed in a voluntary pattern, that we have had a variety of programmes that have evolved such as the municipal programme and so on. That has failed and we have had other experiments and we have again borrowed from them and as they were of service during this time and many of them still are. It allows us to develop the programmes which we think are the best suited to our patients. In other words, evolution rather than revolution.

GOVERNOR: DR. DALVI, on page 6, Paragraph IV the Medical Services Act was put into force in 1937 and five years later, 1942, the Act was repealed. My question is this, for information, and I but I do not; was this rescinding or repealing

any appeal made or some outside pressure brought to bear to have the Act revised or rescinded?

DR. DALVI: No, I think the need had disappeared and the Act was not needed.



new conditions it became obsolete?

DR. DALGLEISH: Yes, that is my interpretation of it.

COMMISSIONER BALTZAN: On the same page, Paragraph 19, you refer to the rapid turnover in municipal doctors, etc. I have one question: do you recall when prepaid medical services were put into practice and it was called then, I think, the pooling of resources. When was it put into practice in the Province of Saskatchewan?

DR. DALGLEISH: 1939 was the first prepaid voluntary organization started in this Province.

COMMISSIONER BALTZAN: Then this Province pioneered in the prepaid pooling of resources' scheme to make medical services available?

DR. DALGLEISH: The answer to that is yes.

DR. BAROOTES: The answer to that is a qualified yes. If my memory of history is correct I believe we incorporated our first plan in 1937 and it became operational in 1939. If my memory is correct the Windsor Medical Plan may have pre-dated the Saskatchewan Plan and you are probably acquainted with the programme in the Windsor area. I think it pre-dated us.

COMMISSIONER BALTZAN: I will be interested to know if the dates for the Medical Co-Op, the first one was not actually in 1937. Could we have that information?

DR. ANDERSON: I think that is correct. If I remember correctly the medical men were prepared to go ahead with the plan and when they learned of the



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new conditions it became obsolete?

DR. DALLBLEN: Yes, that is my inter-

pretation of it.

COMMISSIONER BALTAN: On the same page,

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pal doctors, etc. I have one question, do you recall

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go ahead with the plan and when they learned of the



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2
3 planning of the Medical Co-Op they offered their co-
4 operation to the Medical Co-Op and did not set up the
5 separate organization.

6 THE CHAIRMAN: That is the organization by
7 Dr. Kurtzweiser?

8 DR. DALGLEISH: Yes, in Saskatchewan.

9 COMMISSIONER BALTZAN: Page 9, Paragraph 25
10 reads that there was a fee charged for non-cancer cases
11 that went through the Cancer Commission which was intro-
12 duced then. Why was this nominal fee required? Was it
13 because of the question of a deterrent charge or was it
to help meet costs?

14 DR. DALGLEISH: Taking the last first, I do
15 not think it was done to meet costs. The second point,
16 I believe, it was with the same thought in mind as we
17 speak of deterrents or co-insurance. I believe this was
18 the basis of that fee in hoping that non-precancerous
19 and cancerous disease would be looked after in the usual
20 manner and not come to our cancer clinics in large
numbers.

21 COMMISSIONER BALTZAN: Dr. Dalgleish, can you
22 tell us who implemented that extra charge?

23 DR. DALGLEISH: Well, it was recommended by
24 the Cancer Commission and it was passed by Government.

25 COMMISSIONER BALTZAN: And the composition of
26 that Cancer Commission?

27 DR. ANDERSON: I have it here: this consists
28 of a chairman and six others, one representing the Urban
29 Municipal Association, one the Rural Municipal Associ-
30 ation, one representing the women of the Province, one

planning of the Medical Co-Op they offered their co-operation to the Medical Co-Op and did not set up the

The CHAIRMAN: That is the organization by

Dr. Kurland?

DR. KURLAND: Yes, in Saskatchewan.

COMMISSIONER BARTON: Page 3, Paragraph 25

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and cancerous diseases would be looked after in the

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numbers.

COMMISSIONER BARTON: Dr. Kurland, can you

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DR. KURLAND: Well, it was recommended by

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4 representing the Canadian Cancer Society, Saskatchewan
5 Division and two representing the College of Physicians
6 and Surgeons. The chairman is a medical doctor and there
7 are two ex-officio members, the Director of Cancer
8 Services of the Province and the Director of the Regina
9 Clinic.

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COMMISSIONER BALTZAN: In other words, there
was wide representation of people who saw fit to take
this measure. I am very grateful to you Dr. Smith-
Windsor for having brought to notice in your addendum, as
an addendum in your summary, a reference to the minority
report. I think, Mr. Chairman, I might ask one or two
points here. My question is, is the reason for your
minority report based on the argument that the report by
the majority was incomplete, perhaps premature and that
you had not yet completed all the studies?

DR. DALGLEISH: Well, I will receive help for
this but may I point out that in asking for an interim
report the original terms of reference were narrowed to
Physicians' Services only. With that remark I will ask
the gentleman who had more to do with this than I did to
comment.

DR. ANDERSON: Would you repeat that question
again?

COMMISSIONER BALTZAN: I forget it.

DR. DALGLEISH: You asked --

THE CHAIRMAN: The Reporter will read it back
if you wish.

COMMISSIONER BALTZAN: No, I can do it again.
Is the reason for your minority report based on the

Division and two representing the College of Physicians and Surgeons. The chairman is a medical doctor and there are two ex-officio members, the Director of Cancer Services of the Province and the Director of the Regina Clinic.

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if you wish.

Is the reason for your minority report based on the



argument that the report was premature and incomplete?

DR. ANDERSON: It was based on the fact that we had considered, yes, that the report had been confined to one aspect of the health care and the minority report deals with the question of deficiencies as well as all differences of opinion in regard to the personal services of physicians.

MR. BALTZAN: Any other statement?

DR. BAROOTES: One would have felt that to judge health needs and health care one must do it in the context of all health aspects and the feeling was among some of us in the minority group that --

THE CHAIRMAN: Well, can you add or take away anything from what you read in the minority report?

DR. BAROOTES: No, I do not think so.

THE CHAIRMAN: It is here for all men to read for good or ill.

COMMISSIONER BALTZAN: In respect to lunch time I have just one more question. Yesterday we heard of a new plan that is being evolved now will pay for services at the basic level, we call it the general practitioner level and that specialist will receive some fee. Patients come to see them and they will only receive them if they were referred by a general practitioner. I think I am right in thinking that. My question is this: how does this face up against what we think as the North American custom where people have a free choice to go to whoever they want, a specialist of one kind or another whether they selected rightly or wrongly they can go of their own accord without having to take a chit from their

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COMMISSIONER BRYAN: In respect to January
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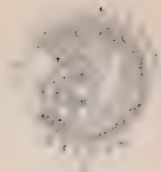
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4 general practitioner to refer them as against the Old
5 Country system based on the Harley Street example where
6 they were limiting themselves to reference cases or cases
7 referred to them. Will that be an infringement on the
8 freedom of patients in thinking of patients first, that
9 they will not under this new plan have that personal
10 satisfaction?

je 10 DR. DALGLEISH: Well, Mr. Chairman, without
11 commenting on what was heard yesterday, could I approach
12 it this way? That it is a custom in this country of
13 Canada, and very much so in Saskatchewan, that patients
14 do go directly to doctors, general practitioners of
15 course in the great majority of cases, but they have the
16 privilege of going directly to a specialist, and this is
17 our traditional pattern of practice in this Country as
18 compared to European customs, and we strongly uphold this
19 tradition here, and feel that any other method would be
20 a control on patients, which we would not favour.

21 COMMISSIONER BALTZAN: I thank you. Mr. Chair-
22 man, I think I have allowed for enough time.

23 THE CHAIRMAN: Thank you, we will now adjourn
24 for lunch, and reconvene at two o'clock, when I will ap-
25 preciate it if you gentlemen will be present.

26 THE SECRETARY: Before we break, Mr. Chairman,
27 may I file as exhibit 80 A , the brief that the
28 Saskatchewan Division of the Canadian Medical Association
29 filed to the Advisory Planning Committee of the Province
30 of Saskatchewan, dated December 1960, and as 80B a further
report, a supplementary submission, dated 9th of July,
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THE SECRETARY: Before we break, Mr. Chairman,
may I file as exhibit 80 A, the brief that the
Saskatchewan Division of the Canadian Medical Association
filed to the Advisory Planning Committee of the Province
of Saskatchewan, dated December 1960, and as 80B a further
report, a supplementary submission, dated 8th of July,



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THE CHAIRMAN: Yes.

---EXHIBIT NO. 80A: Brief of the Saskatchewan Division of the Canadian Medical Association filed with the Advisory Planning Committee of the Province of Saskatchewan dated December, 1960.

---EXHIBIT NO. 80B: Supplementary Submission dated 9th July, 1961.

---LUNCHEON ADJOURNMENT:

---ON RESUMING AT 2:00 P.M.

THE CHAIRMAN: We will come to order and proceed.

COMMISSIONER STRACHAN: You have outlined your list of priorities. Some of you may have heard the question I asked the Minister yesterday to which he gave a definite yes, such groups as retarded children, crippled children, and other such groups as I detailed yesterday, would be cared for under the proposed plan. Where do these groups stand in your consideration?

DR. HUNT: Mr. Chairman and Mr. Commissioner, we regard all this group amongst what we have entitled the Convalescent and chronically ill. They have as high a priority as we give to the aged. We feel that this whole group is of long-standing disability, and should be given one of the top priorities. Personally, I feel they should come top, but certainly this varies, certainly my colleague to the left of me would argue the other way, but at least one of the top ones, and we would lump the group, particularly those with maxillary facial defects and needing dental care.



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4 COMMISSIONER STRACHAN: As we learned yester-
5 day that dentists are not permitted to admit or dis-
6 charge patients from hospital, I presume this is a
7 hospital edict. Are you in agreement or disagreement
8 with such a policy, as a body? We learned, I may add,
9 that in Manitoba such is permitted.

10 DR. BAROOTES: Mr. Chairman and Mr. Commis-
11 sioner, I think this was elaborated upon a bit yesterday.
12 At the present time dentists may admit patients to
13 hospital for advanced extractions for anesthetics, or
14 for procedures they think may require hospitalization.
15 When they do so, for the record they are admitted by the
16 dentist and associated surgeon, doctor, or general
17 practitioner usually.

18 COMMISSIONER STRACHAN: By the physician,
19 that would qualify them all, would it not?

20 DR. BAROOTES: I think so.

21 COMMISSIONER STRACHAN: That term would be
22 all encompassing.

23 DR. BAROOTES: You have a double admission.
24 Before the patient is admitted to hospital the physician
25 completes an admission form, in which he has examined
26 this patient from the viewpoint of his general anesthetic
27 risk. The dentist admits him, treats him, and discharges
28 him. If a complication arises, the physician is avail-
29 able to treat him.

30 The other aspect of your question was, are we
in favour of, . Our hospital service plan, per se
makes arrangements to permit admissions on a short term
arrangement for those procedures, an anoscopic procedure,



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3 and so on, to hospital. That is as far as we have gone.
4 We do not have a dental department in any hospitals with
5 which I am acquainted. There may be in Saskatoon a
6 dental department within the hospital.

7 COMMISSIONER STRACHAN: Would you, as a body,
8 offer encouragement to the establishment of a department
9 of dentistry in the hospital to take care of the groups
10 that I have mentioned beforehand, where they can only be
adequately treated?

11 DR. BAROOTES: Very much so, most definitely
12 so. In some of our out-patient departments we have urged
13 the installation of facilities for the performance of
14 elective and emergency dental surgery, and have not as
15 yet been able to establish such a department. We are
16 also very heartily in favour of your method, or suggested
17 method, of encouragement of dental people into the travel-
18 ling itinerary type, by establishing a dental surgery room
19 with a dentist's chair and electricity, which is very
20 fundamental and necessary, into hospitals, so that a
21 dentist may go to the various towns, and maybe it would
22 encourage a dentist to travel, say two days a week. When
23 it is possible to undertake it, as yet to my knowledge
24 there are not very many of these established in the
25 Province, and I think the Minister, or the Deputy Minister
mentioned yesterday that they hoped there would be one or
two.

26 Another aspect is what we experienced in the
27 Army, and of course with which you are fully acquainted,
28 is the travelling dentist's van, which we have in our
29 divisions, where the electricity was provided by a
30



and so on, to hospital. That is as far as we have come.
We do not have a dental department in any way really with
which I am disappointed. There is a dental school in Saskatoon

other endorsement to the establishment of a dental and
of dentistry in a hospital to take care of the public
that I have mentioned before, where they can only be
dental service.

1. I believe that we need, most definitely

2. In some of our dental hospitals we have urged

the installation of that kind of performance of

effective and economy dental service and have not as

yet been able to establish it in a hospital. We are

also very interested in the kind of dental service, or hospital

service, and arrangement of dental service for the travel-

ling industry type, I estimate a dental service, not

with a dental service and electrician, which is very

important and necessary, in the hospital, so that a

dentist may go to the hospital, and have it well

encourage a dentist to travel, say a day a week, when

it is possible to have him, as yet to my knowledge

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will have to say that they hope to have one or

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army, and of course with which you are fully acquainted.

is the traveling dentist's van, which we have in our

relations, where the electricity was provided by a



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3 generator. This too may have some merit.

4 COMMISSIONER VAN WART: On page 35 of your
5 brief, Section 113, the last two sentences: "There is
6 no guarantee that the amount of revenue allocated by
7 Government will meet the expenditure of the programme.
8 In this event the only recourse of the Commission is to
9 restrict the type or amount of insured services." Could
10 you elaborate a little on that?

11 DR. DALGLEISH: Well, in going over this I
12 would like to say first, the last sentence: "In this
13 event the only recourse of the Commission is to restrict
14 the type or amount of insured services." "Or pro-rate
15 the fees" should be added in there, to make it more
16 understandable we believe. However, that is only in
17 explanation.

18 DR. ANDERSON: Mr. Chairman, if I might add,
19 I would suggest that Government control of hospitals does
20 not necessarily ensure better services. In fact, it has
21 given rise to some curtailment even of hospital services,
22 and I suspect that under a Government --

23 THE CHAIRMAN: Would you first elaborate on
24 the word curtailment?

25 DR. ANDERSON: Yes, curtailment from the stand-
26 point of nursing services, keeping wards open, and such
27 as was touched on this morning at your Hearing.

28 THE CHAIRMAN: Are there any places, Doctor,
29 where the actual bed capacity of a hospital that was op-
30 erating at the time the plan came into force, where the
operating bed capacity of that hospital has been reduced?

DR. BAROOTES: Yes, there have been several of



operation, this is why have some results.

COMMISSIONER: I am sure that you

will, Section 10, and last two or three years is

no guarantee that the amount of revenue obtained by

In this event the only revenue of the Government is to

you also have a large amount of money.

And this is a good thing, isn't it?

Would it be to say that the first of these is this

the first of these is a good thing, isn't it?

the first of these is a good thing, isn't it?

the first of these is a good thing, isn't it?

operation.

DR. WILSON: Yes, that is a good thing, isn't it?

I would think that the first of these is a good thing, isn't it?

not necessarily a good thing, isn't it?

given the fact that the first of these is a good thing, isn't it?

and I suspect that the first of these is a good thing, isn't it?

the first of these is a good thing, isn't it?

the first of these is a good thing, isn't it?

DR. WILSON: Yes, that is a good thing, isn't it?

point of having services, known as a good thing, isn't it?

as was pointed out in the first of these is a good thing, isn't it?

DR. WILSON: Yes, that is a good thing, isn't it?

the first of these is a good thing, isn't it?

DR. WILSON: Yes, that is a good thing, isn't it?



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3 them.

4 THE CHAIRMAN: Is that the kind of thing you
5 are talking about?

6 DR. DALGLEISH: Yes, that would be in the same
7 category.

8 THE CHAIRMAN: Have you any examples?

9 DR. BAROOTES: Sir, there were several examples,
10 I think the year was 1955, in which several hospitals in
11 this Province were re-rated on a new basis of bed rating,
12 changing the standard I believe from one of cubic footage
13 to square footage space. Do you want specific names of
hospitals, from my memory, sir?

14 THE CHAIRMAN: Yes?

15 DR. BAROOTES: Two I would suggest are the
16 Regina Grey Nuns Hospital and the St. Joseph's Sisters
17 Hospital in Estevan, but these were changes in standards
18 of allocating beds in respect of cubic footage. They
19 had switched to square footage, and as you know the old
20 institutions had very high ceilings, which gave a large
cubic footage. This transformed --

21 THE CHAIRMAN: It was to bring it in line, was
22 it not, with Dominion Standards, standards set by the
23 Federal Department of Health?

24 DR. BAROOTES: I believe that is correct.

25 THE CHAIRMAN: So that you cannot lay the blame
26 at the door of the Provincial authority in that respect.

27 DR. BAROOTES: No, I think you are absolutely
28 right. I say it was a changing of standards that neces-
29 sitated a lessening of beds. We have also closed some
30 hospitals in this Province, sometimes because there is not



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3 a doctor available in that area, because he left. An
4 example of this is the hospital at Val Marie. Sometimes
5 it is opened, and sometimes closed.

6 These questions could have been ably answered
7 by my confrere, Dr. Matthews, who was here yesterday and
8 this morning.

9 DR. DALGLEISH: You asked a question that we
10 haven't dealt with --

11 THE CHAIRMAN: I am sorry, you have not dealt
12 with the examples of this diminution of service.

13 DR. HUNT: The hospital that is supposed to
14 lead the way, the University Hospital, Mr. Chairman, ever
15 since 1958 hospital expansion in this Province has been
16 relatively frozen. By that I mean that we are to work on
17 our 1958 budgets plus a small increment in terms of cost
18 of living. Now, in 1958, the University Hospital was not
19 fully developed. It only opened in 1955. A complete
20 range of staff had not been provided in either nursing
21 nor in special fields, such as rehabilitation. By the
22 freezing of the budget in 1958 we have not been able to
23 expand our services as adequately as we would have anti-
24 cipated for a teaching, the teaching hospital in the
25 Province.

26 Another instance, sir, is the lack of funds
27 being made available for the development of physical
28 therapy establishments in the Province in the hospitals,
29 and by and large any development of physical therapy, the
30 equipment for the regional hospitals in this Province has
been through the kind courtesy of the Arthritis Society
making grants available.



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4 COMMISSIONER VAN WART: Is it not true that
5 the voluntary agencies such as you mentioned initiated
6 programmes where Government funds are not available, very
7 often?

8 DR. HUNT: This is true, and this is why the
9 Arthritis Society stepped into the breach, sir.

10 COMMISSIONER VAN WART: In other words, the
11 system of payment by the Government has not flexibility
12 enough to automatically take these newer schemes, or pro-
cesses, in?

13 DR. HUNT: That would be my interpretation, sir.

14 COMMISSIONER VAN WART: Is that implied in the
15 guaranty you speak of?

16 DR. DALGLEISH: In the context of hospitals,
17 yes.

18 COMMISSIONER VAN WART: Do you feel the same
19 way in the context of the medical service programme?

20 DR. DALGLEISH: Yes, sir.

21 DR. BAROOTES: This would be our feeling, sir.
22 One can only conjecture, but not foresee if it is possible.
23 If it is feasible, or possible, if conditions are there to
24 do it.

25 COMMISSIONER VAN WART: You would be controlled
26 by the amount of money in the pot, so to speak?

27 DR. DALGLEISH: That is our fear, and I think
28 it is substantiated by the way the funds are allocated.
29 It is our understanding that the taxes to be collected are
30 to go into general revenue, except for the direct tax of
a premium, which is directly allocated to this programme,
so that any revenues must compete with roads, buildings,



COMMISSIONER VAN WART: Is it not true that the voluntary agencies such as you mentioned initiated programs where Government funds are not available, very often?

MR. KUBIE: This is true, and this is why the Activities Society stepped into the breach, sir.

COMMISSIONER VAN WART: In other words, the system of payment by the Government is not flexible enough to automatically take these newer agencies, or pro-

MR. KUBIE: That would be my interpretation, sir. FOR LESTER VAN WART: Is that right in the country you speak of?

MR. KUBIE: In the context of hospitals, yes.

COMMISSIONER VAN WART: Do you feel the same way in the context of the medical service programs?

MR. KUBIE: Yes, sir.

MR. KUBIE: This would be my feeling, sir. One can only speculate, but not because it is possible it is feasible, or possible, if conditions are there to do it.

COMMISSIONER VAN WART: You would be controlled by the amount of money in the pot, so to speak?

MR. KUBIE: That is our fear, and I think it is substantiated by the way the funds are allocated. It is our understanding that the taxes to be collected are to go into general revenue, except for the direct tax of a premium, which is directly allocated to this program.



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4 and other forms of Government expenditure in this Province,
5 and I think that that is our great concern in this regard,
6 and we have been using some examples to demonstrate this.

7 COMMISSIONER BALTZAN: Is it always money, or
8 could it be in terms of policy? For instance, a hospital
9 may seek to follow, or pursue a course of its own, which
10 in their estimation is appropriate for the locality, and
11 policy might be at variance, and therefore it cannot pro-
12 ceed?

13 DR. DALGLEISH: The answer to that would be
14 yes.

15 COMMISSIONER VAN WART: In Section D of your
16 summary, you specify three groups, or three segments, you
17 call them, of the population, needing subsidy, and on page
18 24, Section 75: " We have concluded that 10 percent of the
19 population may require such assistance." When we were in
20 Manitoba there was a survey made by Professor Barber, a
21 Sociologist, and he said that 25 percent of the population
22 were included in the indigent class, and this class which
23 you have mentioned here was known as semi-indigent, and
24 the indigent, in questioning, he said was 5 percent. That
25 would leave 20 percent, and you mention here that you con-
26 clude that 10 percent of the population might require such
27 assistance. For comparable groups, the figure was 20 per-
28 cent. Have you any explanation, or reason, for arriving
29 at your 10 percent?

30 DR. DALGLEISH: Mr. Commissioner, our research
isn't comparable to the Manitoba effort. That is the first
thing. We have some experience from our doctors in
municipalities and in discussing this at the municipal



other forms of government expenditure in this Province
and I think that is our great concern in this regard,
and we have been using some examples to demonstrate this.
DR. J. L. BATTAM: Is it always money, or
could it be in terms of policy? For instance, a hospital
may seek to follow, or pursue a course of its own, which
in their estimation is appropriate for the locality, and
policy might be at variance, and therefore it cannot pro-
ceed?

DR. J. L. BATTAM: The answer to that would be

yes.

COMMISSIONER: I am sorry, in section 2 of your

summary, you apply these people, or these diseases, you
call them, to the population, medical specialty, and in page
14, section 14: "We have concluded that 10 percent of the
population are relative such assistance" when we were in
Vanikoro there was a survey made by the local people, a
sociologist, and he said that 25 percent of the population
were included in the 10 percent class, and this class which
you have mentioned here was known as semi-indigent, and
the indigent, in question, he said was 5 percent. That
would leave 15 percent, and you mention here that you con-
clude that 10 percent of the population are relative such
assistance. For comparison, please, the figure was 10 per-
cent. Have you any explanation, or reason, for arriving
at your 10 percent?

DR. J. L. BATTAM: I am, Commissioner, not certain

isn't comparable to the Vanikoro effort. That is the first
thing. We have some experience from our doctors in
municipalities and in discussing this at the municipal



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3 level with secretaries and representatives of municipal-
4 ities, and we further have some information from the
5 Swift Current Plan.

6 DR. ANDERSON: Well, I think as you see,
7 Section 79 amplifies it to some extent, Mr. Commissioner.
8 "Support for this estimate of 10 percent is provided by
9 the experience of this Province in the financing of
10 hospital care insurance and by the statement of repre-
11 sentatives of Health Region No. 1." "This estimate,
12 therefore, is a tentative one --."

13 Then, if you turn to Section 81 you see we say
14 it is possible, of course, that 20 percent of the popu-
15 lation would require assistance. As Dr. Dalgleish says,
16 we haven't a firm figure, but we know in the Swift Cur-
17 rent area there are relatively few on whose behalf the
18 Swift Current area have to pay a premium.

19 COMMISSIONER VAN WART: You state the outlay
20 would be 2,212,000 in Section 81, and if you would refer
21 to Section 104 on page 32, you mention the outlay would
22 be 3,600,000 in its first year. Have you any explanation
23 of the discrepancy?

24 DR. BAROOTES: That is the other group -- the
25 over 65 group; a separate group.

26 COMMISSIONER VAN WART: The over 65 group is
27 not included in that first one?

28 DR. BAROOTES: No.

29 COMMISSIONER VAN WART: The whole three seg-
30 ments which I mentioned on Section D, then, are not
mentioned in the first?

DR. BAROOTES: No, that first figure applies

level with secretaries and representatives of municipalities, and we therefore have some information from the

DR. WILKINSON: Well, I think as you say,

the experience of this Province in the financing of hospital care insurance and by the statement of representatives of health service No. 1, "I think definitely,

therefore, as a tentative one -- "

Now, if you turn to Section 81 you see we say

it is possible, of course, that 20 percent of the population would require assistance. As Dr. Wilkinson says, we have a large number, but we know in the light of past experience that we relatively few on whom would the shift of responsibility have to pay a premium.

Now, if you turn to Section 82, you see we say that the cost would be \$2,750,000 in Section 81, and if you would refer to Section 84 on page 82, you would see the outlay would be \$2,600,000 in the first year. There you may explain to the Honorable

DR. WILKINSON: That is the other group -- the

group is known as a separate group.

Now, if you turn to Section 85, you see we say

not included in that first one

COMMISSIONER VAN NEST: The whole thing depends

on which I mentioned on Section 8, then, are not

mentioned in the report?

DR. WILKINSON: No, that first figure applies



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3 to the one group only; that is, the persons of all ages
4 with low income and limited means.

5 COMMISSIONER VAN WART: Would Section 104 in-
6 crease your 10 percent of your population, looking at it
7 in comparison to Manitoba?

8 DR. DALGLEISH: The answer is yes, it does in-
9 crease it; and taking the actual figures, it increases
10 it by nearly another 5 percent.

11 COMMISSIONER VAN WART: So 15 percent would
12 compare with your 20 in Manitoba?

13 DR. DALGLEISH: Yes.

14 DR. BAROOTES: An explanation is necessary.
15 Swift Current health region is 50,000 people, in the
16 southwestern corner of our Province which, as some of
17 you will recall, was the worst drought hit area in our
18 country during the '30's. It is a fairly comparable
19 area now. Oil and other modalities of industry have
20 helped them a bit, but we take them to be a rather
21 average rural area. In asking their representatives
22 previously as to how many people could not pay the ap-
23 proximately \$100. charge per year -- that is, \$48. to
24 \$50. for medical care and about \$40. or \$45. for the
25 hospital care -- their representatives estimated it at
26 one time to be as low as 3 percent; in other words, for
27 3 percent of their people the municipality had to pay
28 this up to the central fund and then try to collect it
29 back from the indigents or near indigents -- or, as
30 you call them, semi-indigents. We felt this was too
low on further studies, and we graded it up to 10. You
realize, if it was raised to 20 percent, which the



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4 Manitoba survey indicated, it may be a larger figure. As
5 you will recall, Dr. Barber's excellent report was based
6 on a survey which they had done as social scientists and
7 social economists and what they would regard as an ac-
8 cepted standard of living for this type of group, and in
9 some instances it was fairly substantial. This is the
10 only explanation we can give you. Our figures were ar-
11 rived at by consultation with other people. As a matter
12 of fact we used somebody from Mercer and Company to as-
13 sist us with these payments: Mr. Dennis George, and Mr.
14 Freamo has freely given his advice as well.

15 COMMISSIONER VAN WART: I don't know whether
16 you can answer this or not. If you can't we will get it
17 from the voluntary plans when they appear. Have you any
18 idea what the total amount of premiums paid in the vol-
19 untary plans and insurance companies is in this Province?

20 DR. BAROOTES: In dollars per year?

21 COMMISSIONER VAN WART: Yes.

22 DR. BAROOTES: This is both line companies --

23 COMMISSIONER VAN WART: Everything.

24 DR. BAROOTES: I think you will find that in
25 the Thompson Report. As a matter of fact, there was a
26 composite figure from D.B.S. plus the other department.

27 DR. DALGLEISH: We will look for that, sir.

28 COMMISSIONER VAN WART: What I was driving at
29 was whether the sum of this 3,600,000 people and this
30 other figure would be anywhere near the estimate of
20,500,000?

DR. BAROOTES: Highly doubtful, sir, because
if you added the line companies -- that is, the insurance

Manitoba survey indicated, it may be a larger figure. As you will recall, Mr. Hadden's excellent report was based on a survey which had been completed in 1934. Social economists and what they would regard as an accepted standard of living for the type of group, and in some instances it was fairly substantial. This is the only explanation we can give you. Our figures were arrived at by comparison with other groups. As a matter of fact we have received from Hadden and Company to assist us with the payment. Mr. Hadden's figure, and Mr.

Mr. Hadden's figure, I don't know whether you can answer this or not. If you can't we will get it from the voluntary group when they report. Have you any idea what the total amount of payment would be for the voluntary group and how many companies is in this Province?

Mr. Hadden: In 1934 two years ago.

Mr. Hadden: Yes.

Mr. Hadden: This is from the companies --

Mr. Hadden: Everything.

Mr. Hadden: I think you will find that in the Thompson factory, as a matter of fact, there was a composite figure from D.C.E. plus the other payment.

Mr. Hadden: We will look for that, sir.

Mr. Hadden: Yes, sir. I was advised that was whether the sum of \$2,500,000 people and this other figure would be payments near the estimate of \$2,500,000.



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4 companies selling health insurance -- to the voluntary
5 doctor-sponsored non-profit plans, I think your figure is
6 likely somewhere in the area of \$7,000,000. I am guessing,
7 but you are leaving out the 50,000 people in Swift Current;
8 you are also leaving out 140,000 on municipal plans; you
9 are leaving out several other large groups of segments of
10 society, plus the 33 percent who pay as they go.

11 COMMISSIONER VAN WART: Would the total of
12 this and the 3,600,000 exceed the 20.5 million?

13 DR. BAROOTES: I think it would be considerably
14 less. I am not sure of the point, Mr. Chairman and Mr.
15 Commissioner: are you aiming that the total sum that we
16 are estimating for our new medical care programme of 21
17 million, approximately, is a higher figure than the figure
18 expended in this Province on health the previous year?

19 COMMISSIONER VAN WART: Yes.

20 DR. BAROOTES: The figure of 21 million is
21 higher than that figure. The last year we had on record
22 was 18.7, that I was aware of this Province.

23 THE CHAIRMAN: 18 million ??

24 DR. BAROOTES: Yes. I think that was 1959 --
25 1959-60. Dr. Freamo may have some knowledge of this from
26 Ottawa.

27 DR. FREAMO: The report of the Thompson
28 Committee lists the voluntary and private medical care in-
29 surance premiums as \$6,500,000 in Saskatchewan.

30 THE CHAIRMAN: What page is this?

DR. FREAMO: It is page 31 of the printed vol-
ume of the Advisory Planning Committee, the interim report.
This is \$6.5 million of voluntary and private insurance,



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4 and it also lists just over \$1 million for the municipal
5 doctor plans in the Province. So, this would give about
6 \$7.5 million as total premiums, total costs paid for
7 private and municipal doctor programmes.

8 COMMISSIONER VAN WART: It is quite safe to
9 state, then, that 21 million dollars would be larger than
10 all these other sums?

11 DR. DALGLEISH: In our opinion, yes.

12 COMMISSIONER VAN WART: Now, come to page 6,
13 no. 18, regarding the municipal doctor system: you state
14 that it does not generally provide for ready referral
15 for specialist attention and that indeed it may have in-
16 hibited the more adequate distribution of medical specialists
17 in the Province. Could you elaborate on that for me?

18 DR. DALGLEISH: Well, Mr. Commissioner, the
19 set-up of the municipal contract is generally a contract
20 to one doctor, or sometimes more than one, but usually
21 one for all the general practitioner services in the area
22 and does not provide for, usually, any specialist payments,
23 and so the restriction is economical really in some degree
24 on the patient, and there is not usually any mechanics
25 set up for referring the patient readily from the plan,
26 and some municipalities have felt that in a case where
27 a doctor did use referrals widely that it became too
28 costly for whatever portion they were paying for referrals,
29 and there are limits of freedom here for both the patient
30 and the doctor.

COMMISSIONER VAN WART: The next paragraph,
19, the first sentence: "The rapid turnover of municipal
doctors has not been conducive to the continuity of



and it also just over 25 million for the municipal
doctor plans in the Province. So, this would give about
25.5 million for total operations, total costs paid for
private and municipal doctor programmes.

... in our opinion, yes.

... regarding the municipal doctor system: you state
that it does not generally provide for really relevant
for specialist education and that it may have im-
paired the more adequate distribution of medical specialists
in the Province. Could you elaborate on that for me?
...
... of the municipal doctor system is generally a constraint
to one doctor, or sometimes more than one, but usually
one doctor, and the spread of specialists is not good
and does not provide for, usually, any specialist services
and so the restriction is not really in some degree
on the patient, and there is not usually any restriction
set up for restricting the patient really from the plan,
and some municipalities have felt that in some cases
a doctor and one specialist who is becoming too
costly for whatever reason they were paying for specialists
and there are limits of freedom there now both the patient
and the doctor.

... the 3rd sentence: "The rapid turnover of municipal
doctors has not been conducive to the continuity of



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3 medical services in the areas concerned, and it has
4 been found in many situations that the enrollment of
5 municipalities by prepaid medical services insurance
6 provides a more acceptable alternative." Would you
7 elaborate on that somewhat for me?

8 DR. DALGLEISH: Mr. Commissioner, we would
9 be, I think, repeating what I have already stated, and
10 that is that under the Medical Services there is freedom
11 of choice of doctor, not only locally but in reference
12 to specialists at some distance. In general, although
13 proving more costly than a straight municipal contract
14 patients have accepted it and liked it, and doctors have,
15 in our opinion, been more inclined to stay and give
service to that area.

16 DR. BAROOTES: Mr. Chairman and Mr. Commissioner,
17 I think the meaning of this is that at one time the muni-
18 cipal plans were extremely useful, held the doctor in
19 the community in the time of a depression. Things have
20 changed somewhat. The municipal plans now are not quite
21 as useful as they were, although they are still good,
22 we think. A young doctor coming to Saskatchewan from
23 outside would be tempted to take municipal practice be-
24 cause there is a guaranteed salary with it, but there
25 are some controls on the patient and there are some
26 controls on the doctor. The patient has to go to that
27 doctor for certain treatments, and if he refers then out
28 he has to occasionally get permission from the local
29 secretary who signs the referral slip etcetera. This
30 sometimes leads to a little trouble: one doctor does
certain procedure, and another doesn't. So, these

medical services in the areas concerned, and it has
been found in many instances that the enrollment of
municipalities by private medical services increases
provided a more acceptable alternative. Would you

elaborate on that somewhat for me?

DAVIDSON: Mr. Commissioner, we would

be, I think, repeating what I have already stated, and
that is that under the Medical Services there is freedom
of choice of doctor, not only locally but in reference
to specialists at some distance. In general, although
providing more nearly than a municipal hospital control

in our opinion, seem to be inclined to stay and give

service to that area.

OK, Mr. Davidson. Mr. Davidson, the

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capital plans are extremely costly, and the doctor in
the community in the time of a depression. There have
changed somewhat. The municipal plans are not quite
as useful as they were, although they are still good,
we think. A young doctor coming to Washington from
outside would be tempted to take municipal hospital ser-
vice there is a guaranteed salary with it, but there
are some controls on the patient and there are some
controls on the doctor. The patient has to go to that
doctor for certain treatments, and if he refuses then out
he has to occasionally get permission from the local
secretary who signs the referral slip etcetera. This
sometimes leads to a little trouble; one doctor does
certain procedure, and another doesn't. So, these



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4 doctors shop around: they may be in a municipality with
5 one scheme and move to another one, and so on. Our plan
6 M.S.I. has pioneered something which I believe is worth-
7 while: they have signed up whole communities, entire
8 communities, on a voluntary basis, and in signing them
9 up they have converted a fairly large number of municipal
10 doctor plans into the service plan of the non-profit
11 organization; some of them with only 8 percent coverage,
12 some with 50. But they have accepted many of them. Our
13 experience has been a pioneer one in this, but it is
14 proving the people are satisfied with it and, indeed,
15 doctors tend to stay in these certain communities which
16 have switched much longer than did their previous in-
17 cumbents. I think that is the referral we make.

16 THE CHAIRMAN: What is the experience in
17 staying or turnover in the Swift Current health area?

18 DR. BAROOTES: Of doctors?

19 THE CHAIRMAN: Yes, of doctors? Have you any
20 figures on that?

21 DR. ANDERSON: My understanding is that the
22 turnover there is somewhat in the neighbourhood of some-
23 what less than three years on the average. They tend to
24 come and go more regularly, I believe, than in other
25 parts of the Province. Maybe our Registrar would know.

26 DR. PEACOCK: The last time we figured it out
27 the average length of stay was as Dr. Anderson suggested.

28 THE CHAIRMAN: Three years?

29 DR. PEACOCK: Two or three years.

30 THE CHAIRMAN: How does that compare with
other parts of the Province -- not a health unit.

one scheme and move to another one, and so on. But plan
... has provided something as a basis for work.
... they have started up with organized, entire
communities, on a voluntary basis, and in giving them
up they have converted a fairly large number of non-
doctor plans into the service plan of the non-profit
organization; some of them with only 8 percent coverage,
some with 50. But they have accepted many of them. On
experience has been a lesson one in this, but it is
proving the people are entitled to it and, indeed,
doctors tend to stay in these certain communities which
have withdrawn much longer than did their previous
patients. I think that is the reason we make.

staying on turnover in the United States health care

THE CHAIRMAN: Yes, of course.

Witness on that?

DR. ANDERSON: My understanding is that the
turnover there is somewhat in the neighborhood of 20
what less than three years on the average. They tend to
come and go more regularly, I believe, than in other
parts of the Province. Maybe our Registrar would know.
DR. FRANK: The last time we turned it over
the average length of stay was as Dr. Anderson suggested.

DR. BECKER: Two or three years.

parts of the Province -- not a health unit.



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4 DR. PEACOCK: I didn't estimate the other
5 areas, but from my experience in the office I would say
6 the turnover in the Swift Current area is more rapid than
7 comparable areas elsewhere.

8 COMMISSIONER VAN WART: In the areas where
9 the prepaid medical insurance is used, the plan pays the
10 doctor -- or, does the plan pay the municipality where he
11 is on salary?

12 DR. BAROOTES: The usual method is for the money
13 to be collected by the rural reeve or rural secretary
14 and paid monthly or quarterly to M.S.I. The doctor bills
15 M.S.I. and is paid in the same way as for every other
16 Medical Services Incorporated account. It also permits
17 the patient to leave that municipality and seek treatment
18 anywhere under his contract -- anywhere, really, in Canada,
19 and elsewhere for emergencies.

20 COMMISSIONER VAN WART: Coming to the second
21 sentence of Paragraph 19: "Unfortunately, the economic
22 circumstances of a few municipalities and unorganized areas
23 is such that prepayment by insurance is not feasible." My
24 question is, the basic subsidy -- to whom is that payable?
25 The municipality or to the doctor?

26 DR. DALGLEISH: We had envisaged it being paid
27 to the doctor in the area.

28 DR. ANDERSON: There are probably four or five
29 areas, remote areas, in the Province where we felt there
30 would be some reason for providing for a subsidy for the
doctor or part salary basis for him to establish himself
in these remote areas, and possibly have his income added
to by this.



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... but from my experience in the office I would say

... compared to other elements.

... COMMUNIST VAN WART: In the areas where

the prepaid medical insurance is used, the plan pays the

doctor -- or, does the plan pay the municipality where he

... THE SALES MAN: The usual method is for the money

to be paid to the municipality or to the secretary

and paid monthly or quarterly to M.B.A. The doctor bills

himself and I paid in the same way as for every other

medical services and hospital account. It also permits

the patient to have that municipality and each treatment

... anywhere under the plan -- anywhere

... COMMUNIST VAN WART: Coming to the second

... of paragraph 10 "Constitutionally, the economic

... of the municipalities and organizations and

... of the municipalities and organizations and

... of the municipalities and organizations and

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4 DR. BAROOTES: This is being done now, Mr.
5 Chairman. There is Lac La Ronge which is an opening
6 area in our lake area, and there is a doctor there sub-
7 sidized by the Provincial Government. There are two
8 other areas -- Ile a la Crosse, way up north in our
9 non-organized northern administration area, and here too
10 the Provincial Government arranges a subsidy because of
11 the sparse population etc. Another form of subsidy
12 which has been considered, and which may be feasible and
13 even more acceptable would be to establish -- and I think
14 this has been put to you, sirs, previously in Manitoba
15 -- the establishment of proper facilities for the doctor
16 who comes to a small community from an urban education,
17 such as the provision of home and certain things, so that
18 he can come and stay, and, if he leaves, not take a
19 large capital loss by trying to find a buyer for his
20 facilities -- his office and his home. This has been
21 done in areas in Saskatchewan, and we think it will help
22 with the geographic distribution of doctors and facilities.

23 DR. DALGLEISH: Almost all in the northern
24 part of the Province.

25 COMMISSIONER VAN WART: In coming to these
26 remote areas, Section 114 on page 35, the analogy was
27 brought out in another province that Boards of Education
28 see that in these remote areas every child received an
29 education, and I notice that you in this section state
30 that that analogy is fallacious due to the fact the
Boards of Education in these areas have fiscal authority
to assess whatever costs are necessary for their edu-
cational system. Would you visualize a medical care

La Ronge which is an

aided by the Provincial Government. There are two
other areas -- the La Crosse, way up north in our
non organized northern administration area, and here too
the Provincial Government arranges a subsidy because of
the sparse population etc. Another form of subsidy
which has been considered, and which may be feasible
even more desirable would be to establish -- and I think
this has been put to you, mine, particularly in Manitoba
-- the establishment of a school district for the school
who comes to a small community from an urban education,
such as the provision of home and maintenance, so that
we can come and stay, and if we cannot, not take a
large capital loss by trying to find a buyer for the
property -- in the office and has a home. This has been
done in areas in Saskatchewan, and we think it will help
with the geographic distribution of schools and facilities.
Dr. O. A. A. Almost all is one northern

WORTHINGTON, WAB: In coming to these

more areas, Section 11, on page 33, the analogy was

and that in these remote areas every child receives an
education, and I notice that you in this section state
that that analogy is fallacious due to the fact the
boards of education in these areas have fiscal authority
to assess whatever costs are necessary for their edu-



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4 situation in that area granting similar fiscal authorities,
5 and be operated somewhat like the schools are built and
6 operated -- only health centres being built and operated
7 in these remote areas?

cH/je 7 DR. DALGLEISH: It was not our thinking in the
8 proposals in our brief. Has anyone else any thoughts on
9 this?

10 DR. ANDERSON: I think this is a new thought
11 on this that had not occurred.

12 DR. DALGLEISH: We had thought that these
13 areas were probably very few in number and rather than
14 set up any local machinery we would feel they could be
15 subsidized directly probably by Government.

16 COMMISSIONER VAN WART: In other provinces the
17 percentage of population in these areas is quite large
18 and I wondered if the same thing would apply to your
19 province?

20 DR. BAROOTES: Except for Uranium City which
21 started out this way and we think this should be temporary.
22 Most of these areas are very sparsely populated, Uranium
23 City is no longer on this subsidized list since its settle-
24 ment and hospital development there. There are mostly
25 trappers and fishermen people and they are there more in
26 the summer than in the winter.

27 COMMISSIONER VAN WART: Would a system of
28 transportation be of value in that area?

29 DR. BAROOTES: It would be extremely costly to
30 put in road types of transportation but such suggestions
as your organization gave, such a thing as a flying doctor
visiting was suggested. Now, Australia has such a programme



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3 and sometimes one wonders if it is not better to have the
4 flying transportation bring the seriously injured person
5 to the centre where the facilities exist rather than
6 taking a bare-handed doctor with few instruments out to
7 an outpost where he may not have all the necessary faci-
8 lities. Both of these things have been entertained.

9 Also consultant services and our pediatric
10 brethren have mentioned this on several occasions that
11 it might be possible and feasible for a team of doctors
12 by air to travel into these places, they have to land on
13 lakes, and give consultation services to groups of people
14 who are notified of their arrival. This is another pos-
sibility.

15 COMMISSIONER VAN WART: Is it possible to put
16 workshops in these areas or are they too scattered for
17 workshops? I mean small cottage type hospitals.

18 DR. BAROOTES: Well, I think the Lac la Ronge
19 now has one unless it was recently burned down which is
20 one of the catastrophes which occasionally occurs.
21 Uranium City has a good hospital. Ile a la Crosse has
22 an outpost hospital and I should add most of these were
23 Red Cross outpost hospitals and continue to be. I think
24 Ile a la Crosse is a Red Cross -- I might be wrong in
that.

25 THE CHAIRMAN: That is one left.

26 COMMISSIONER VAN WART: Page 9, Section 25
27 the last line speaking about cancer control as you say:
28 "...a nominal fee of \$10. was introduced to
patients found not to have a cancer."

29 To whom does that fee go?
30



to the centre where the facilities exist rather than
taking a bare-handed doctor with few instruments out to
an outpost where he may not have all the necessary facil-
ities. Most of these things have been entertained.

operation have mentioned this on several occasions that
it might be possible and feasible for a team of doctors
to go to travel into these areas, they have to land on
boats, and this condition has been to provide of people
who are needed at such activities. This is another pos-
sibility.

operation in these areas of the country is a matter of
workshops. I mean all different types of facilities.
on activities. I think the idea is to have
now has the idea it was to have a few more which is

operation (it has a good hospital). It is in Cross has
an outdoor hospital and I found that most of these were
for these outdoor hospitals and activities to be. I
think the Cross is a lot better -- I might be wrong

THE CROSS. That is the last.
COMMUNICATIONS. The last of the 9, Section
line connecting about seven control as you say.
"...a number of the 910 was introduced as
near."



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3 DR. DALGLEISH: Directly to the Cancer
4 Commission.

5 COMMISSIONER VAN WART: And on page 13, Para-
6 graph 36, the last sentence:

7 "In the larger centres, the occupancy rate
8 is 90 percent whereas in the smaller hospitals the
9 average is 65 percent."

10 Is there any explanation of the difference?

11 DR. DALGLEISH: Well, in building our hospitals
12 in this province in the original planning we did not al-
13 low for the shift in population from rural to urban
14 centres that has taken place in the last ten years and
15 with it the institution of good roads. As a result of
16 that our hospitals have a tendency -- our beds seem to
17 have a tendency to be in the wrong places so the situ-
18 ation arises where a hospital, a larger hospital is situ-
19 ated and the population in the area has become smaller.
20 It also takes into account that some small hospitals do
21 not have a doctor for a while and they are closed or they
22 have an occupancy rate that is absurdly low for a period
23 of time when a neighbouring doctor may come in and ser-
24 vice that hospital.

25 DR. BAROOTES: There was a feeling among those
26 who guided the policy immediately after the Second World
27 War that one way of attracting bright young doctors into
28 rural areas was to establish a hospital which would be
29 an attraction to keep the doctors there. Our hospital
30 survey committee now is undertaking a re-review of this
information and in questioning the department on other
occasions I think they were having a good hard critical



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3 look at whether this idea of the small eight, ten or
4 twelve bed units in the smaller areas is a wise move.

5 COMMISSIONER VAN WART: There is also a flow
6 from the smaller hospital to the larger hospital?

7 DR. BAROOTES: Constantly.

8 COMMISSIONER VAN WART: Which would tend to
9 keep one down and the other up. Page 16, Paragraph 46
10 you speak about nursing homes and you say:

11 "This would be a useful field for Government
12 subsidy which could be limited to financial assist-
13 ance for needy individuals -- "

14 Is there a Government subsidy of any form at
15 the present time?

16 DR. DALGLEISH: Yes, my understanding is there
17 is a subsidy on a selective basis and that a nursing
18 home does apply for this subsidy where a patient cannot
19 pay for the necessary accommodation or does develop a
20 need for greater service. Dr. Hunt, have you anything
21 to say on that?

22 DR. HUNT: That is about the extent of my
23 knowledge on this situation. By and large the private
24 nursing homes have to charge somewhere in the neighbour-
25 hood of \$120. to \$130. a month. A lot of individuals
26 who have reached the stage where they need this type of
27 care cannot afford it and they can get individual assistance
28 if they are over 65 and pass a means test which they can
29 apply to this, but if they have not got enough then
30 either subsidy should be provided or their individual
financial resources should be increased.

COMMISSIONER VAN WART: In the case of the



look at whether this idea of the small eight, ten or
twelve bed units in the smaller areas is a wise move.
COMMISSIONER VAN WART:

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which would tend to
keep one down and the other up. Page 16, paragraph 10
you speak about nursing homes and you say:

"This would be a useful field for government
subsidy which could be limited to financial assist-
ance for needy individuals --
is there a Government subsidy of any form in

DR. BABCOCK: Yes, my understanding is that

pay for the necessary accommodation of beds is a
need for motor service. But, I think, and you say
to say on this

DR. BULL: That is about the extent of my

understand that to which I am referring. I am not
told of \$100 to \$150 a month. A lot of individuals

apply to this, but if they have not got over it then

COMMISSIONER VAN WART: In the case of the



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4 needy in these nursing homes the subsidy is not large
5 enough, you think, it should be increased?

6 DR. DALGLEISH: What I say is my understanding
7 in discussing this with the people that operate such
8 nursing homes is that they do obtain assistance in some
9 cases in depth to the full amount of \$130. that it may
10 take but people in other categories probably not under
11 the Social Welfare Department cannot obtain this help.

12 There is no policy of subsidization but rather selective
13 subsidy for certain cases which in our opinion could be
14 remedied by some standards and some criteria laid down
15 for such subsidies on a much wider scale.

16 DR. BAROOTES: Several of our nursing homes,
17 the big and better nursing homes as you know are operated
18 by our Department of Social Welfare as hospitals and not
19 as homes. For instance, the Regina Nursing Centre, the
20 Geriatric Centre here is actually operated not by our
21 Department of Public Health & Social Welfare. I think
22 the Minister touched on that yesterday and I would hope
23 that the Minister, the Honourable Mr. Nicholson will give
24 you a better understanding. We were very much impressed
25 in our studies with the efficacy of establishing nursing
26 homes under voluntary and religious agencies throughout
27 communities in other countries that previously existed
28 in our own country here. I noticed in Holland and other
29 countries that we made some study of that. This is a very
30 fine feature of the programme that the Provinces assist
these programmes in the establishment and operation of
these nursing homes by some form of financial assistance
and allow the voluntary agency who are most capable of



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operating them efficiently and economically to operate them and allows people to go into them. I can think of homes like -- I think we still have an Orange Home in Saskatoon.

THE CHAIRMAN: Indian Head.

DR. BAROOTES: That the planners and plotters should be talking these things over; this modality of our philosophy is gradually disappearing and yet it is being maintained in the Scardinavian countries and some of the European countries very adequately.

THE CHAIRMAN: I wonder if you are completely accurate in that? Have there not been some of those homes built in recent years?

DR. BAROOTES: Some.

THE CHAIRMAN: St. Anne's?

DR. BAROOTES: Yes, and the Lutheran.

THE CHAIRMAN: And in Saskatoon?

DR. BAROOTES: We think this is a trend that should be encouraged rather than having institutions established in which people go by application through a means test which appears to be 90 percent of our admissions to the Regina Geriatric Centre at the present time, about 90 percent.

THE CHAIRMAN: But there is the subsidization to a considerable degree available by way of grant and by way of a per diem allowance to such homes?

DR. BAROOTES: Yes, there is, sir.

DR. HUNT: One of the greatest problems that the Home for the Aged has is that the home is built for well, old people who are well today and the grants which

operating them efficiently and economically to operate them and allows people to go into them. I can think of homes like -- I think we still have an Oranger home in

DR. WOODHEAD: That the planners and planners should be taking these things over; this mobility of our philosophy is gradually disappearing and yet it is being maintained in the form of various countries and some of the European countries as very adequately.

THE CHAIRMAN: I wonder if you are completely accurate in that? Now there has been some of these homes built in recent years.

BARONESS: Yes.

THE CHAIRMAN: At, I think.

BARONESS: Yes, and the Government.

THE CHAIRMAN: And in Scotland?

BARONESS: We think this is a trend that should be encouraged rather than having institutions established in which people go by application through a means test which appears to be 90 percent of our age relevant to the region's health needs of the present time, about 90 percent.

to a considerable degree available by way of grant and by way of a person's allowance for such homes?

DR. HUNT: One of the greatest problems the the Home for the Aged has is that the home is built for well, old people who are well today and the grants will



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3 they receive, the monies which they collect from their
4 church organizations or for the needy are based on this
5 assumption. Now, everybody knows that a person does
6 not remain healthy forever, particularly at the age of
7 70 or 75. The average age in the Lutheran Home in
8 Saskatoon when we did a survey several years ago was 79.
9 Now, they have been unable to afford to provide extra
10 care for the people who live with them when they get
11 sick. Now, some of them get acutely sick and have to be
12 hospitalized and they may pass away in the hospital or
13 they could get better and come back. They may go back
14 with some residual disability that needs some extra care,
15 a little bit of personal care -- not necessarily profession-
16 al care but personal care and they are unable with the
17 grants and the rates which they have to provide this.
18 It is one area where I think subsidization is not ade-
19 quate, and that is what we mean in Chapter 40 which is
20 very important.

21 THE CHAIRMAN: Is there not a per diem rate
22 available and paid where they will provide in bed care
23 for the inmate who takes ill -- comes in as an ambulance
24 case and takes ill while in the home?

25 DR. HUNT: According to the nursing home
26 supervisor it is not enough to do this job of work.

27 THE CHAIRMAN: So it is a matter of increasing
28 that per diem rate, that would have quite a good salu-
29 tory effect?

30 DR. HUNT: Yes.

DR. BAROOTES: We run the gamut from the
pioneer village to the acute bed in the hospital. Our



they receive, the only thing

that they receive is for the work that they do

and that is the only thing that they receive

and that is the only thing that they receive

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and that is the only thing that they receive

DR. HUNT: Yes.

DR. WELCH: We run the school from the

nearest village to the school in the hospital.



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4 people need all these facilities. You have a married
5 couple living in the married couple's home in the Pioneer
6 village and the wife dies so the husband is left alone.
7 You have to move them progressively through different
8 units, back and forth and this is what our Departments of
9 Welfare are attempting to do. There should be a little
10 bit of praise in this regard because it is a very dif-
11 ficult job and particularly when you are doing it in
12 urban as well as in rural communities it is a real prob-
13 lem in trying to work it out.

14 THE CHAIRMAN: Dr. Hunt, what is the name of
15 the Institution on Avenue P. north of the hospital?

16 DR. HUNT: That is the Mount Royal Lodge.
17 That is just a hotel, if you like to call it, for older
18 people. It is partially supported, partially subsidized.

19 THE CHAIRMAN: The principal monies have come
20 from National Housing?

21 DR. HUNT: That is right, for capital con-
22 struction.

23 DR. DALGLEISH: And voluntary agencies?

24 THE CHAIRMAN: And when you become ill in that
25 situation you go to a hospital?

26 DR. HUNT: It is the only place you can go
27 unless you are fortunate enough to have your name in on
28 the waiting list for a geriatric centre.

29 DR. DALGLEISH: That is under the Department
30 of Welfare and Hospitalization, a different department.
We have observed a difficulty in making, in having flexi-
bility between those two departments in moving these
people around from hospitals to nursing homes to



people need all these facilities. You have a married couple living in the married couple's home in the... illness and the wife died so the husband is left alone. You have to move them progressively through different units, back and forth and this is what our Department of Welfare are attempting to do. There should be a little bit of money in this regard because it is a very difficult job and particularly when you are doing it in urban as well as in rural communities it is a real problem in trying to work it out.

THE CHAIRMAN: Now, what is the plan of the institution on Avenue B south of the city hall? That is just a hotel, is it? You like to call it a hotel?

THE CHAIRMAN: The principal wanted to have a home

DR. HUNT: That is right, for capital and

DR. HUNT: And voluntary agencies?

THE CHAIRMAN: And when you become ill in that

attention you go to a hospital.

DR. HUNT: It is the only place you can go... relate and are fortunate enough to have your name in the waiting list for a residential center.

DR. HUNT: That is under the Department of Welfare and Hospitalization, a different department... between those two departments in moving them



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4 situations where they can look after themselves. I do
5 think that a great deal can be done if this could be co-
6 ordinated not only in using our beds much more advantageously
7 but with greater service to our people. They take sick
8 in these nursing homes and cannot get into a hospital or
9 a place where they can receive real nursing attention.

10 DR. ANDERSON: I think it should be brought
11 out that there is a committee set up by the Government
12 called the Study Committee for Aged and Long-term Ill-
13 nesses. However, the disadvantage with that committee,
14 it is that it is on a three-year study and they have not
15 given any report, it would seem not even any preliminary
16 report on their studies. I might also say that in
17 Australia they seem to have an adequacy of these nursing
18 homes for people and they are subsidized in the building
19 programme by the Government and for the most part are run
20 by religious orders.

21 COMMISSIONER VAN WART: Passing on to E, the
22 rehabilitation, is that shortage acute or is it a relative
23 shortage?

24 DR. HUNT: It is very acute and I am sure you
25 have heard this everywhere you have been. We need at
26 least twice as many physiotherapists in this Province as
27 we have for programmes already in existence. The Canadian
28 Conference in Physiotherapy last May estimated that this
29 figure held for the entire Dominion. The same thing with
30 occupational therapists, we need approximately three times
as many occupational therapists. Social workers could
possibly come up to even a dozen times more than we have
now.

situations where they can look after themselves. I do think that a great deal can be done if this could be coordinated not only in using our beds much more advantageously but with greater service to our people. They take sick in these nursing homes and cannot get into a hospital or a place where they can receive real nursing attention. DR. ANDERSON: I think it should be brought out that there is a committee set up by the Government called the Study Committee for Aged and Long-term Illnesses. However, the disadvantage with that committee, it is that it is on a three-year study and they have not given any report, it would seem not even any preliminary report on their studies. I might also say that in Australia they seem to have an adequacy of these nursing homes for people and they are subsidized in the building programme by the Government and for the most part are run by religious orders.

COMMISSIONER VAN WART: Passing on to B, the rehabilitation, is that shortage acute or is it a relative shortage? DR. HUNT: It is very acute and I am sure you have heard this everywhere you have been. We need at least twice as many psychiatrists in this Province as we have for programmes already in existence. The Canadian Conference in Psychiatry last May estimated that this figure held for the entire Dominion. The same thing with

as many occupational therapists. Social workers could possibly come up to even a dozen times more than we have



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4 COMMISSIONER VAN WART: Is there a shortage
in acute hospitals of rehabilitation services?

5 DR. HUNT: Yes, sir. Every hospital but one.

6 COMMISSIONER VAN WART: And that is a public
7 hospital, is it, a general?

8 DR. HUNT: No, no, that is my own institution,
9 the University Hospital. We fortunately seem to have
10 enough, but this is the first time in our six years of
operation that we have reached that level.

11 COMMISSIONER VAN WART: You have no rehabi-
12 litation centres in this Province?

13 DR. HUNT: We have two sir, one in Saskatoon
14 and one in Regina. They are both, I believe, certainly
15 the one in Saskatoon is, under-staffed. I believe the
16 one in Regina is too.

17 COMMISSIONER VAN WART: Page 36, Section 116,
18 the end of the first paragraph: " -- medical services
19 insurance." You mean the Medical Insurance Act, do you
20 not? Then you go on to say: "The amount of money in-
21 volved and the method of financing this undertaking --",
22 that is the Medical Insurance Act, " -- will, in our op-
23 inion, very effectively diminish the possibility of im-
24 plementing, from tax monies, essential programmes of
25 mental health services, improvement of general hospital
26 services, facilities for convalescents, chronic and re-
27 habilitation care." In other words, you are stating
28 that after the Medical Services Act, the Insurance Act,
comes into force, that there will be a more acute short-
age of money for these various services?

29 DR. DALGLEISH: Well, Mr. Commissioner, I
30



COMMISSIONER VAN WART: Is there a shortage

in acute hospitals of rehabilitation services?

COMMISSIONER VAN WART: And that is a good

hospital, is it, a general?

the University Hospital. We fortunately seem to have
enough, but this is the first time in our six years of
operation that we have reached that level.

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tation centers in this Province?

DR. HUNT: We have two, one in Saskatoon

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the end of the third paragraph: " -- medical services
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not? Then you go on to say: "The amount of money in-
volved and the extent of financing this undertaking --"

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plementing, from tax monies, essential programs of
mental health services, improvement of general hospital
services, facilities for convalescents, chronic and re-
habilitation care." In other words, you are stating

that after the Medical Services Act, the Insurance Act,
comes into force, that there will be a more acute short-
age of money for these various services?

DR. BALGELISH: Well, Mr. Commissioner,



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3 think if you look at it this way. These urgent needs
4 are not being met at the present time. Secondly, there
5 is not much sign that a programme for, either to implement
6 the Saskatchewan Plan, or in the other areas of deficiencies
7 that we have discussed, is taking form at the present time.
8 There is no indication that steps are being taken to
9 cover it, and the reason given is that there is a short-
10 age of money. This problem of finance becomes compounded
11 with the introduction of yet another Medical Care Insurance
12 programme, the cost of which is only being speculated at
13 at the present time, and where the money in general is
14 going into general revenue, we believe that the tax dollar
15 is only so big, that the health dollar is only so big,
16 and it will diminish the possibility of implementing
these essential programmes.

17 COMMISSIONER VAN WART: You would consider
18 these should have priority over a medical care insurance
19 programme?

20 DR. DALGLEISH: Yes.

21 COMMISSIONER VAN WART: And coming to the last,
22 the last page, Section 119, I think Mr. Chairman I could
23 give them the assurance which they ask here: "We would
24 recommend to this Royal Commission on Health Services a
25 thorough study of all health services avoiding undue con-
26 centration on medical services insurance such as we have
27 encountered in Saskatchewan." I think we can give them
28 that assurance, can we not?

29 THE CHAIRMAN: Our purpose is to carry out our
30 terms of reference, and if that is a proper interpretation
of it, that is what we will do.



think if you look at it this way. These urgent needs are not being met at the present time. Secondly, there is not much sign that a programme for, either to implement the Saskatchewan Plan, or in the other areas of deficiency that we have discussed, is taking form at the present time. There is no indication that steps are being taken to cover it, and the reason given is that there is a shortage of money. This problem of finance becomes complicated with the introduction of yet another medical care insurance programme, the cost of which is only being specified at the present time, and where the money in general is

is only so big, that the health policy is only so big, and it will diminish the possibility of implementing these essential programmes.

MR. WATSON: You would consider these should have priority over a medical care insurance

DR. WATSON: Yes.
MR. WATSON: And coming to the next

Give them the assurance which they ask here: "We would recommend to this Royal Commission on Health Services a thorough study of all health services avoiding undue concentration on medical services insurance such as we have encountered in Saskatchewan." I think we can give them that assurance, can we not?

THE CHAIRMAN: Our purpose is to carry out our terms of reference, and if that is a proper interpretation of it, that is what we will do.



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4 I put this question this morning to the Hon-
5 ourable Mr. Davies, requesting production of the letter
6 which went forward asking for the Interim Report from the
7 Advisory Committee on Medical Care. Was the Interim
8 Report the only reply or response of the Advisory Plan-
9 ning Committee to that letter requesting the Interim
Report?

10 DR. ANDERSON: Yes, there was a letter in
11 answer to the Minister's request.

12 THE CHAIRMAN: I take it that letter went to
13 the Minister?

14 DR. ANDERSON: The letter went to the Minister,
15 yes.

16 THE CHAIRMAN: Well, we will ask the Minister
17 for that.

18 COMMISSIONER FIRESTONE: Mr. Chairman, I have
19 a number of questions on principles raised, and I shall
20 be addressing them to Dr. Dalglish, but please, Dr.
21 Dalglish, feel free to pass on these questions to any
22 of your colleagues, so the fact that I address you
personally does not mean that I am not very anxious to
have the use of any of your associates.

23 First, we might want to try to establish what
24 are some of the objectives that your Association is
25 recommending in endeavouring to achieve improved and
26 extended health care services in the Province of
27 Saskatchewan, and I am looking at Paragraph 115, page 35,
28 of the mimeographed text, and I quote as part of an ex-
29 tract of that paragraph: "That the College of Physicians
30 and Surgeons of Saskatchewan endorses the principle of

I put this question this morning to the Hon-
ourable Mr. Davies, requesting production of the letter
which was forwarded asking for the Interim Report from the
Advisory Committee on Medical Care. Was the Interim
Report the only reply or response of the Advisory Man-
aging Committee to that letter requesting the Interim

Dr. Anderson: Yes, there was a letter in
answer to the Minister's request.
THE CHAIRMAN: I take it that letter went to
the Minister?

COMMISSIONER WILKINSON: Mr. Chairman, I have
a number of questions on principles raised, and I shall
be addressing them to Mr. Dalglish, not please, Dr.
Dalglish, feel free to pass on these questions to any
of your colleagues, so the fact that I address you
personally does not mean that I am not very anxious to
have the use of any of your associates.

First, we might want to try to establish what
are some of the objectives that your Association is
recommending in endeavouring to achieve improved
extended health care services in the Province of
Saskatchewan, and I am looking at paragraph 11,
of the mimeographed text, and I quote as part of
that paragraph: "The Saskatchewan Association of
and Council of Saskatchewan"



1 universal availability of prepaid medical insurance."

2
3 In trying to establish what you mean by universal avail-
4 ability of prepaid medical insurance, I have turned to
5 the brief which your Association has submitted to the
6 Advisory Committee of the Province of Saskatchewan on
7 Medical Care, the Planning Committee, and I find on page
8 23 that you expand this principle a little further, by
9 saying: "That you favour the expansion of medical care
10 insurance so that it is available to all residents, re-
11 gardless of age, state of health, or financial status.
12 We believe that this result can obtain without the intro-
13 duction of a compulsory Government-controlled medical
14 service insurance programme." I take it, Dr. Dalglish,
15 that any statement contained in your brief submitted to
16 the Advisory Planning Committee on Medical Care applies
17 also as part of your submission to this Royal Commission?

18 DR. DALGLISH: Yes, Mr. Commissioner.

19 COMMISSIONER FIRESTONE: Now, may I take it
20 from these two quotations, Dr. Dalglish, that you are
21 in favour of a scheme which is available to everybody in
the Province of Saskatchewan?

22 DR. DALGLISH: Mr. Commissioner, I wonder
23 if you would define scheme to me a little more clearly?

24 COMMISSIONER FIRESTONE: I will use the phrase
25 which you have used, and that is prepaid medical insurance,
26 plan if you wish, programme if you wish, scheme if you
wish, is available to everybody.

27 DR. DALGLISH: Yes.

28 COMMISSIONER FIRESTONE: What would be
29 covered under such a prepaid medical insurance plan?
30



In trying to establish what you mean by universal availability of prepaid medical insurance, I have turned to the brief which your Association has submitted to the Advisory Committee of the Province of Saskatchewan on Medical Care, the Planning Committee, and I find on page 28 that you expand this principle a little further, by saying: "That you favour the expansion of medical care insurance so that it is available to all residents, regardless of age, state of health, or financial status. We believe that this result can obtain without the introduction of a compulsory government-controlled medical service insurance programme." I take it, Dr. Daigleish, that any statement contained in your brief submitted to the Advisory Planning Committee on Medical Care would also be part of your submission to the Royal Commission.

DR. DAIGLEISH: Yes, Mr. Commissioner.
 COMMISSIONER FERGUSON: Now, may I take it from these two quotations, Dr. Daigleish, that you are in favour of a scheme which is available to everybody in the Province of Saskatchewan?

DR. DAIGLEISH: Mr. Commissioner, I would like if you would define scheme to me a little more clearly.
 COMMISSIONER FERGUSON: I will use the phrase which you have used, and that is prepaid medical insurance plan if you wish, programme if you wish, scheme if you wish, is available to everybody.

COMMISSIONER FERGUSON: What would be covered under such a prepaid medical insurance plan?



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3 Do you have in mind comprehensive medical care services?

4 DR. DALGLEISH: Mr. Commissioner, generally
5 speaking, yes. In this Province we have had some ex-
6 perience with patient responsibility in small areas,
7 chiefly house calls and office calls, which are called
8 co-insurance, or sometimes utilization fees, and with our
9 experience we in general mean a comprehensive programme
10 subject to the experience that we are gaining through
11 patient responsibility in some areas as a cost control.

12 COMMISSIONER FIRESTONE: What do you have in
13 mind, sir, under the heading Cost Control?

14 DR. DALGLEISH: Well, in any plan or prepaid
15 insurance, the cost may mount with increasing utilization
16 by patients and over-servicing by physicians. The two
go probably hand in hand.

17 COMMISSIONER FIRESTONE: I take it from what
18 you have been saying that you are in favour of a voluntary
19 plan?

20 DR. DALGLEISH: Yes indeed.

21 COMMISSIONER FIRESTONE: Are you in favour of
22 non-profit plans, such as you have in Saskatchewan under
23 the Medical Care Service etc.? These are co-operative
plans?

24 DR. BAROOTES: Are we in favour of all plans
25 being non-profit plans?

26 COMMISSIONER FIRESTONE: No, this is not the
27 question I asked. I said, are you in favour of non-profit
28 plans such as you have in the Province of Saskatchewan
under the Medical Care Service programme?

29 DR. BAROOTES: The answer to that question is
30

Do you have in mind comprehensive medical care services?

Speaking, yes. In this Province we have had some experience with patient responsibility in small areas, chiefly house calls and office calls, which are called co-insurance, or sometimes utilization fees, and with our experience we in general mean a comprehensive programme subject to the experience that we are gaining through patient responsibility in some areas as a cost control.

COMMISSIONER FIRSTMAN: What do you have in

mind, sir, under the heading Cost Control?

DR. DALWORTH: Well, in any plan or prepaid insurance, the cost may mount with increasing utilization by patients and over-serving by physicians. The two

are probably hand in hand

COMMISSIONER FIRSTMAN: I take it from what

you have been saying that you are in favour of a voluntary plan?

COMMISSIONER FIRSTMAN: Are you in favour of

non-profit plans, also as you have in Saskatchewan under

these are co-operative

plans?

DR. BARSTON: Are we in favour of all plans

COMMISSIONER FIRSTMAN: No, this is not the

question I asked. I said, are you in favour of non-profit

plans such as you have in the Province of Saskatchewan

BARSTON: The answer to that question is



no, for the following reasons. We believe that the
divers needs of different groups of society and indivi-
duals within a group vary considerably. We, as a
College of Physicians and Surgeons are at the present
time supporting a service plan which is a non-profit plan.
We have founded them, we have sponsored them, and we
seem to favour them for our patients. In this category
the doctors sign up as participating physicians, and
take a discount on their fee in order to have these plans,
and we feel that in many aspects this is a good type of
medical care insurance for groups of people to have. On
the other hand, there are some other types of medical
care insurance, such as the indemnity type, which is sold
by companies which at the present time are not necessarily
non-profit. Some of them are losing propositions, but
some of them are profitable propositions, and some of
them break even. These companies do serve a most useful
purpose, and we would feel that the exclusion of them
from the field, as long as they have a good range of
the benefits, and as long as they carry on under the
proper Act of Government, should be encouraged to com-
plement our plans, and I say this for a specific reason
sir. The reason I say this is that the needs of indi-
viduals vary, and I will give a couple of examples.
Some of the plans in other countries didn't develop on
the basis of medical care insurance, but on the basis
of out of work benefits. The Norwegian plans for ex-
ample, in other words my need and someone else's need
in health care might not be the same, because of our
situation, work, etc. I give you concrete examples.



diverse needs of different groups of society and individuals within a group vary considerably. We, as a College of Physicians and Surgeons are at the present time supporting a service plan which is a non-profit plan. We have founded them, we have sponsored them, and we seem to favour them for our patients. In this category the doctors sign up as participating physicians, and take a discount on their fee in order to have these plans, and we feel that in many respects this is a good type of medical care insurance for groups of people to have. On the other hand, there are some other types of medical care insurance, such as the indemnity type, which is sold by companies which at the present time are not necessarily non-profit. Some of them are losing propositions, but some of them are profitable propositions, and some of them break even. Those companies do serve a most useful purpose, and we would feel that the inclusion of them from the fund, as long as they have a good chance of the benefits, and as long as they carry on within the proper act of government, should be encouraged to complement our plan, and I say this for a specific reason also. The reason I say this is that the needs of individuals vary, and I will give a couple of examples. Some of the plans in other countries didn't develop on the basis of medical care insurance, but on the basis of out of work benefits. The Norwegian plans for example, in other words my need and someone else's need in health care might not be the same, because of our situation, work, etc. I give you concrete examples.



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3 Our programmes of service insurance, which are non-
4 profitable, do not carry any of the other protections
5 which certain citizens or groups may require. Some people
6 require far more than the payment of a bill for a tonsil-
7 ectomy or appendectomy, or the payment of a bill for a
8 fracture of his leg. Some of these workmen, people with
9 families, or homemakers, require weekly disability, be-
10 cause they are out of work, and if they do not have it
11 the six children and the wife at home are doing without.
12 We do not have weekly disability. Many of the company
13 plans do, for B.A. Oil and others do have it. If I were
14 to lose my right arm, Mr. Commissioner, the cost of the
15 medical fee, which might be \$150. to a competent surgeon,
16 is not going to do me much good. What I need is a dis-
17 ability insurance, and many of the commercial firms, and
18 workmen's compensation boards for that matter, carry these.
19 It is not a bad idea for these families and groups,
20 particularly the breadwinner, to obtain with his insurance
21 a certain degree of protection in the form of group life
22 insurance, which is helpful. Our programmes do not cover
23 the divers needs of divers groups in our society, and we
24 think they are a good complement to us.

25 COMMISSIONER FIRESTONE: Dr. Barootes, you are
26 a good champion of commercial insurance plans --

27 DR. BAROOTES: Not necessarily, sir.

28 COMMISSIONER FIRESTONE: At least judging by
29 the length of your answer.

30 THE CHAIRMAN: No, I do not think that. I
think Dr. Barootes' answer was a responsive one to the
question put to him.

...of the ... which are non-

profitable, do not carry any of the other protections which certain citizens or groups may require. Some people require far more than the payment of a bill for a tonsillectomy or appendectomy, or the payment of a bill for a fracture of his leg. Some of these workers, people with families, or homekeepers, people weekly, or fifty, because they are out of work, and if they do not have it the six children and the wife at home are doing without. He do not have weekly disability. Many of the company want to, for T.A. and others do have it. If I want to lose my right arm, Mr. Commissioner, the cost of the medical fee, which might be \$100, to a competent surgeon, is not going to do me much good. What I need is a disability insurance, and many of the commercial firms, and

It is not a bad idea for these families and groups, particularly the localities, to obtain with his insurance a certain degree of protection in the form of group life insurance, which is helpful. The program does not cover the lives needs of diverse groups in our society, and we think they are a good complement to us.

COMMISSIONER ELLISTON: Dr. Barcotes, you are

a good champion of commercial insurance plans --

COMMISSIONER ELLISTON: At least judging by

the length of your answer.

THE CHAIRMAN: No, I do not think that. I

think Dr. Barcotes' answer was a responsive one to the

question put to him.



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3 COMMISSIONER FIRESTONE: I would like to pur-
4 sue this question a little further. You have expressed
5 yourself in favour of commercial plans in addition to
6 non-profit plans. Are you familiar that the standards
7 which these plans offer vary quite a bit, plus the
8 conditions?

9 DR. BAROOTES: I have some familiarity with
10 them through the Superintendent of Insurance's Annual
11 Provincial Report, sir.

12 COMMISSIONER FIRESTONE: Do I take it, Dr.
13 Barootes, that there are some plans in some commercial
14 policies which are going a good deal further than others,
15 and that there are some that make rather liberal use of
16 the cancellation rights which are reserved to them under
17 the contracts which they offer?

18 DR. BAROOTES: Quite so.

19 COMMISSIONER FIRESTONE: Now, have you, either
20 yourself or any of your associates here, had any ex-
21 perience or complaints from patients who were unable to
22 have their medical bills paid as a result of the use of
23 such cancellation clauses?

24 DR. BAROOTES: Yes, I might say that I didn't
25 say that all programmes of all line insurance companies
26 were good. I said those which have a good range, or
27 comprehensive range of benefits, and good coverage, may
28 be excellent ones. Some, as you know, at the other end
29 of the stick are very bad. Some at the top end of the
30 stick are as good as any of the plans that the doctors
have promoted in this country.

COMMISSIONER FIRESTONE: In other words, you



COMMISSIONER: I would like to see this question a little further. You have expressed yourself in favour of commercial plans in addition to non-profit plans. Are you familiar with the standards which these plans often vary quite a bit, plus the conditions?

DR. BARON: I have some familiarity with them through the Department of Insurance's annual Provincial Report, etc. I think it is a little bit different, that there are some plans in some countries, policies which are not as good as others, and that there are some that are better than others. The cancellation rights which are reserved to the policyholder, which are not the same in all cases.

yourself or any of your associates here, had any experience or knowledge from patients who were unable to have their medical bills paid as a result of the fact that such cancellation clauses?

DR. BARON: Yes, I might say that I don't say that all programmes of all the insurance companies were good. I said those which have a good range, or comprehensive range of benefits, and good coverage, may be excellent ones. Some, as you know, at the other end of the stick are very bad. Some at the top end of the stick are as good as any of the plans that the doctors



are not in favour of all plans, but you are in favour of plans that are comprehensive and give the insured a reasonable coverage and return?

DR. BAROOTES: Correct, sir.

COMMISSIONER FIRESTONE: Now, if that is your view, would you be in favour, and your Association in favour, of controlling such plans to establish minimum standards?

DR. BAROOTES: I am not sure that we have ever discussed this as a group within our medical council, sir. We have discussed it in organizations such as G.M.S. and in other discussions. I believe that there is an Act which governs the operation of insurance companies, which is a statute in each Province, and I believe it is regulated by a Superintendent of Insurance. I have often looked at their book annually. It is usually two years late, as you know, coming out for some reason or other, and when I see it I notice that some company has paid out in benefit dollars some 30 percent. I am somewhat dismayed, but then when I look at the number of people underwritten and find that there were only 17 people underwritten in my Province, I realize that they have a lucky year. Some of the programmes do need enlargement, and I think they are doing the same as every other programme is doing, trying to get on a sound basis before they extend themselves into other fields of benefit. I do decry the cancellation clause, and as you know more and more of these companies are taking steps to try and institute so-called non-cancellable, they are sometimes called non-cancellable, they are sometimes non-renewable.



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else that a

able coverage and return

MR. BARTON: Correct, sir.

COMMISSIONER VIKSTROM: Now, if that is your

view, would you be in favour, and your association in

favour, of controlling such plans to establish minimum

standards?

MR. BARTON: I am not sure that we have

ever discussed this as a group within our medical community.

Mr. Barton, we have discussed it in organizations such as C.M.A.

and in other discussions. I believe that there is an

act which governs the operation of insurance companies,

which is a statute in each province, and I believe it is

regulated by a Superintendent of Insurance. I have often

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they or the themselves into other fields of benefit. I

do deny the cancellation clause, and as you know more

and more of these companies are taking steps to try and

institute so-called non-cancelable, they are sometimes

called non-cancelable, they are sometimes non-renewable.



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3 In any event, I think every type of insurance offered is
4 a help. I think they are all helpful.

5 COMMISSIONER FIRESTONE: Dr. Dalglish, if I
6 may re-state the question. If we find as a result of the
7 survey of the Legislation governing insurance companies
8 established under Provincial statutes, or established
9 under Federal statutes we find that there is no control
10 over the terms under which they, these companies may
11 offer such policies, or incomplete, or inadequate control
12 to achieve the objective, the objective being to assure
13 a minimum standard of coverage, and the minimum set of
14 conditions under which cancellations can take place, to
15 assure that there is a reasonable service of coverage
16 provided, and we find that this is found as a result of
17 a survey which this Commission would undertake, would
18 your group be in favour of amendment of this type of
19 legislation to introduce a minimum of control over com-
20 mercial plans?

21 DR. DALGLEISH: I really don't think I can
22 answer that question, sir. We are in favour of the con-
23 trols -- standards being set up. When you go so far as
24 to say to amend the legislation, you have moved beyond
25 my knowledge of this.

26 COMMISSIONER FIRESTONE: In other words, if
27 I understand you correctly you are in favour of the
28 principle of control and would leave it to those who are
29 more familiar with the legislation to see what is the
30 best way of achieving that objective: am I correct in
that understanding?

DR. DALGLEISH: I would agree with you except



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3 for the word "control". Should it not be that they
4 qualify to a certain standard?

5 COMMISSIONER FIRESTONE: Would I, then, under-
6 stand that you would be in favour if the superintendents
7 of insurance were given the right to enforce the achieve-
8 ment of minimum standards?

9 DR. DALGLEISH: Yes.

10 COMMISSIONER FIRESTONE: Thank you very much.
11 May I now turn to a brief discussion of the principles
12 underlying the Swift Current Medical Care programme. I
13 am turning to page 55 of the brief to the Advisory
14 Planning Committee on Medical Care, and I am particularly
15 referring to Part II, which is a brief of the Swift
16 Current and District Medical Society. In this particular
17 section a summary is offered of the achievements and the
18 attitudes, both public and that of the physicians, to-
19 wards the achievement of this programme. If I may quote
20 from this report, and I am using the first brief. The
21 first conclusion was that the Swift Current Medical Care
22 programme as far as the public is concerned, "...are
reasonably well satisfied with the medical services they
are receiving."

23 The second conclusion is, "These services
24 are being financed through a personal and land tax --
25 utilization fees paid directly by the patients for some
26 services received -- Government grants and subsidization
by the profession."

27 And the third conclusion offered is --

28 THE CHAIRMAN: "Observation" rather than
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"for the word 'control'". Should it not be that they

quality of a certain standard?

COMMISSIONER: I think, would I, then, would

stand that you would be in favor of the superintendent
of insurance were given the right to enforce the achieve-

ment of minimum standards?

MR. DALLMAN: Yes.

May I now turn to a final question: the principle

relating to the State Department and the program. I

am going to refer to the letter to the Advisory

Learning Committee on Medical Care, and I am particularly

referring to Part II, which is a list of the Staff

Current and District Medical Society. In this, not only

section a summary is offered of the activities and the

attitudes, with which and that of the physician, the

would the main body of this program. If I may refer

from this record, and I am using the first part. The

first conclusion was that the State Current Medical Care

program as far as the public is concerned, "...and

reasonably well satisfied with the medical services now

are provided.

The second conclusion is, "These services

are being financed through a personal and local tax --

utilization fees paid directly by the patients for ser-

vice -- and -- Government grants and subsidies for

by the physician.

And the third conclusion offered is --



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"conclusion", Dr. Firestone. Since you are quoting, I think it is better to use the language.

COMMISSIONER FIRESTONE: Yes, Mr. Chairman; I was quoting Paragraphs 1, 2 and 3.

THE CHAIRMAN: Yes, but you were saying they were conclusions. The opening paragraph says, "...the following observations."

COMMISSIONER FIRESTONE: That is quite correct, Mr. Chairman. The word in the text is "observations".

Paragraph (3) "The doctors of the Region are also reasonably satisfied with the programme."

Now sir, can you just summarize for the benefit of this Commission the method by which this Swift Current Medical Care programme is paid?

DR. BAROOTES: At the present time?

COMMISSIONER FIRESTONE: At the present time, sir.

DR. BAROOTES: Simply, you mean how are the doctors paid?

COMMISSIONER FIRESTONE: Well, how is the medical care programme paid for?

DR. BAROOTES: How is it financed?

COMMISSIONER FIRESTONE: Yes, how is it financed?

DR. BAROOTES: I believe, if I am correct -- I thought it was reviewed in our little brief, but I presume it was overlooked. It is financed first on a head tax, which is, I believe, arranging --

THE CHAIRMAN: At the foot of page 53.

DR. BAROOTES: Yes; a head tax plus a land tax plus a small grant from the Provincial Government,



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4 which amounts to, I think, about \$1. a head for the
5 population, which comes close to about \$50,000., which
6 would be about 6 or 7 percent. This is the regular
7 public health grant which is available to any region
8 which undertakes such a programme.

9 COMMISSIONER FIRESTONE: In other words, we
10 have here a programme that has been tried for a number
11 of years in the Province of Saskatchewan, that has been
12 found acceptable to the people that are enjoying the
13 benefits of the programme, that has been found acceptable
14 to the physicians participating in it, which covers
15 everybody in the Swift Current area, and with the payments
16 or the financing of the plan being made (a) through
17 premium payments, (b) through taxes and (c) through some
18 contribution by physicians, because, as it says here,
19 subsidization by the profession, which I presume is that
20 the profession is prepared to take somewhat less than the
21 fee schedule?

22 THE CHAIRMAN: Plus a Provincial grant equi-
23 valent to about 6 percent.

24 COMMISSIONER FIRESTONE: Well, I presume, Mr.
25 Chairman, when I used the phrase " taxation " I referred
26 to general revenue, and general revenue, whether it comes
27 from local sources or provincial sources, would be covered
28 under the heading of taxation.

29 We have here, then, a plan that covers every-
30 body in the Province, that is, as I said, partly premium
31 financed, partly tax financed and partly financed by the
32 contribution of physicians. Would you say this plan is
33 a compulsory plan?

which amounts to, I think, about \$1. a head for the population, which comes close to about \$20,000, which would be about 4 or 5 percent. This is the regular public health grant which is available to any region which undertakes such a programme.

COMMISSIONER FLEWELL: In other words, to have been a programme that has been tried for a number of years in the Province of Saskatchewan, that has been found acceptable to the people that are enjoying the benefits of the programme, that has been found acceptable to the physicians participating in it, which covers everybody in the Swift Current area, and with the amount on the financing of the plan being made (a) through premium payments, (b) through taxes and (c) through some contribution by physicians, because, as it says here, subsidisation by the profession, which I presume is that the profession is prepared to take somewhat less than the fee schedule?

THE CHAIRMAN: This is a Provincial grant also.

valent to about 5 percent.

COMMISSIONER FLEWELL: Well, I presume, Mr.

Chairman, when I used the phrase "taxation" I referred to general revenue, and general revenue, whether it comes from local sources or provincial sources, would be covered under the heading of taxation.

We have here, then, a plan that covers every-

body in the province, that is, as I said, partly premium financed, partly tax financed and partly financed by the contribution of physicians. Would you say this plan is

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DR. DALGLEISH: Yes.

COMMISSIONER FIRESTONE: Would you say this plan is a comprehensive plan?

DR. DALGLEISH: Reasonably so, yes; it has utilization fees, but reasonably so. It is quite limited in its referrals for specialist referrals outside the region, but apart from that, comprehensive services.

COMMISSIONER BALTZAN: What happens to these people who are referred outside of the Swift Current area and must have a specialist consultation?

DR. DALGLEISH: 50 percent of the schedule of fees is paid.

COMMISSIONER BALTZAN: Who pays that?

DR. DALGLEISH: The region.

COMMISSIONER BALTZAN: And who pays the balance?

DR. DALGLEISH: The patient.

COMMISSIONER FIRESTONE: I take it, sir, that we have here a programme which, as you indicated, is compulsory, which you indicated is comprehensive, and which you indicated is tax supported?

DR. DALGLEISH: Yes.

COMMISSIONER FIRESTONE: Since this programme apparently is acceptable and has been fairly successful in the Swift Current area, what are your views about expanding this particular type of operation to the rest of the Province of Saskatchewan?

DR. DALGLEISH: I would have to make, Mr. Commissioner, some comment about the Swift Current plan. This region of 50,000 people has complete fiscal autonomy



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4 and control of their funds. They had a referendum in
5 the area before they adopted this plan. Either side of
6 the district society or the regional board can terminate
7 their contract on notice of three months. It is negoti-
8 ated annually. The monies, as I have said, that go into
9 this programme are not in competition with other costs
10 to that area. We feel and really believe this is a large
11 municipal programme in this area, and we are not in
12 favour of an extension of such a plan to the whole
13 Province.

14 COMMISSIONER FIRESTONE: Could you give the
15 Commission the reasons for not being in favour of such
16 a programme -- of the extension of such a programme?

17 DR. DALGLEISH: The fears that we have in ex-
18 panding of any programme are in the same category as a
19 monopoly that would be one single mechanism for the
20 payment in this Province of everybody. This, of course,
21 would jettison the present medical care programmes that
22 we have. There would be real danger of possibly freezing
23 the evolution of medical care insurance at the level when
24 one single programme went into effect. As we look around
25 we do not know in the future the path that medical care
26 insurance may develop. In 10 or 15 years the trend in
27 psychiatric care, the care for the aged, diseases of the
28 vascular system, arterial sclerosis -- 10 or 15 years,
29 the pattern of treatment and changes in treatment, in
30 care of our patients, may change, and to adopt a single
mechanism at the present time that would perhaps prove
inflexible would, we think, be bad for our patients and
for the doctors.

and control of their funds. They had a referendum in the area before they adopted this plan. Either side of the district society on the regional board can terminate their contract on notice of three months. It is a right stated annually. The money, as I have said, then go into this programme and not in competition with other costs to that area. We feel and really believe this is a very municipal programme in this area, and we are not in favour of an extension of such a plan to the whole Province.

Commission the money for not being in favour of such a programme -- of the extension of such a programme. Dr. [Name] said: The fact that we have in the handling of any programme in the area, and we are not necessarily that would be one of the reasons for the payment in that [Name] of [Name]. This, of course, would [Name] the present medical [Name] programmes [Name] we have. The [Name] is [Name] of possibly [Name] the evolution of medical [Name] insurance at the [Name] one single programme went into [Name]. As we look [Name] we do not know in the future the path that medical [Name] insurance may develop. In 10 or 15 years the [Name] psychiatric care, the care for the aged, diseases of the vascular system, mental [Name] 10 or 15 years, the pattern of treatment and charges in treatment, in care of our patients, new ideas, and to adopt a single mechanism at the present time that would perhaps [Name] inflexible would, we think, be bad for our patients and for the doctors.



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3 COMMISSIONER FIRESTONE: Well, sir, if I may
4 read you a conclusion offered in the brief on this very
5 point at page 26: "The doctors in Swift Current would
6 caution those who might consider that a programme which
7 is satisfactory in Swift Current can be expanded to cover
8 the whole population of this Province. They are convinced
9 that the local nature of operation has been a necessary
10 requisite for the programme's success."

11 If the same principles which have contributed
12 to the successful operation of this programme in Swift
13 Current could be applied to other areas, what would be
14 your objection on that basis?

15 DR. BAROOTES: The objections are the ones
16 that the doctors in the region had voiced, and that is
17 that what runs well locally, with a good esprit des corps
18 and good communication and good rapport between the
19 regional health board and the doctors and the patients
20 in the area, may not work from a central contract agency
21 in the City of Regina. You must realize that this plan
22 has been brought along step by step. Although it was a
23 compulsory plan from the beginning, after the referendum
24 and consent with the doctors, that there have been a
25 variety of changes made to make the plan acceptable -- I
26 should not use the term "acceptable": to make the plan
27 more workable -- because it always worked. And in ex-
28 tending this one can see a great many difficulties both
29 administrative and otherwise in trying to set up, if you
30 are conceiving some 13 or 14 regional plans co-ordinated
in Regina. Another sample of difference is that this is
essentially a rural area with general practitioners'



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3 service primarily, and has virtually no specialists'
4 service in the area at all. In fact, there appears to
5 be some indication from our best studies in the College
6 and in the Thompson Committee and from the evidence given
7 by their secretary, Mr. Robertson, at open public hearings,
8 that there seems to be a tendency for specialists to keep
9 out of such a programme, and this would be a tragedy if
10 one had such a programme universally throughout Saskatchewan.
11 I am not quite sure from your question if you would en-
12 visage 13 such programmes in the Province, or one programme
13 of the same nature.

14 COMMISSIONER FIRESTONE: I am inquiring whether
15 the principles that underly the Swift Current experiment
16 which has proven to be successful could be applied, with
17 some appropriate modification to suit a particular region,
18 to other regions, and I presume that physicians and people
19 in other regions presumably could co-operate as well as
20 they have done in Swift Current and develop a somewhat
21 similar programme, adopting the same principles?

22 DR. BAROOTES: This was gone into very fully
23 in the Thompson Committee, and if you would read the
24 reasoning reports in the majority section you will see
25 that this was rejected as a modality or instrument of
26 introducing regional health care for a Provincial pro-
27 gramme with a central administration. You must realize,
28 sir, that a referrendum held in Swift Current in, I think,
29 1947 or so was responsible for this programme. We take
30 credit as medical men in saying that we are not in-
flexible, that we like flexibility, experimentation and
competition of the various types of programme, to compare



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4 them, and if one was certain right now that this is the
5 only good programme, I think one could go along with it,
6 but we are not certain this is the only and best programme
7 now and evermore, and if we want to immediately jump on
8 it -- we as doctors, and citizens as citizens, and you
9 as a recommending Board. But we are not certain we want
10 to channel it all one way. In 1955 a similar referrendum
11 was held in this Province in the Regina health region,
12 which is an area surrounding Regina of some 75,000 or
13 77,000 residents, not including the City of Regina. At
14 the same time, a similar referrendum was held in
15 Assiniboine-Gravelburg, which is adjacent to the Swift
16 Current area. In the latter, rejections by the voters,
17 I believe, was in the order of 4 to 1, and in the Regina
18 rural region, over 2 1/2 to 1. In other words, the people
19 of the area by referrendum rejected such a programme.

20 DR. ANDERSON: Mr. Chairman, I think it would
21 only be fair to also point out -- I think if you give
22 proper reading to this summary and other comments you
23 will find this is not considered to be an ideal programme,
24 that there are voiced in it certain reservations, that it
25 is reasonably well satisfying, that there are high utili-
26 zation rates, the relative lack of specialists, and that
27 the profession has no voice in certain matters. By no
28 means is it indicated it is an ideal programme. But it
29 has been a worth-while experiment, I would submit.

30 COMMISSIONER FIRESTONE: We expect it, sir.
I don't think anyone can visualize really an ideal pro-
gramme, but taking the experience you have had, my main
question is whether the principles that have been applied



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which is an area surrounding Regina of some 75,000 or
77,000 residents, not including the City of Regina. At
the same time, a similar referendum was held in
Assiniboine-Sourthern, which is adjacent to the Swift
Current area. In the latter, rejected by the voters,
I believe, was in the order of 5 to 1, and in the Regina
health region, over 2 1/2 to 1. In other words, the majority
of the area by referendum rejected such a programme.
Dr. [Name], Mr. [Name], I think it would
only be fair to also point out - I think if you go
properly looking to this assembly and other comments you
will find there is not considered to be an ideal programme,
that there are voiced in it certain reservations, that it
is reasonably well satisfied, that there are high utility
ration rases, the relative lack of specialists, and that
the profession has no voice in certain matters. By no
means is it perfect, it is an ideal programme. But it
has been a long-time experiment, I would submit.
CONSIDERABLE FIRST: We expect it, sir.
I don't think anyone can visualize really an ideal pro-
gramme, but taking the experience you have had, my main
question is whether the principles that have been applied



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4 in this experiment, and which have proven to be success-
5 ful to the satisfaction of both the people of the region
6 and the physicians, could not be applied elsewhere.

7 Dr. Barootes, you referred me to the main
8 body or the main recommendation of the majority report
9 of the Thompson Committee. May I remind you that the
10 majority report was not supported by the three physician
11 members?

12 DR. BAROOTES: That is correct.

13 COMMISSIONER FIRESTONE: Therefore, what I am
14 searching for are the views of your association and not
15 the known views of the Thompson Committee. Do I under-
16 stand from what you have said that you would find it dif-
17 ficult to apply these principles, and perhaps one of the
18 reasons was that the more comprehensive plan that has
19 now been proposed does not follow one of the very specific
20 advantages of the Swift Current experiment, and that is
21 that this was really a local plan, a regional plan,
22 having fiscal authority, and not being controlled by
23 Government; is that your main objection?

24 DR. BAROOTES: That is the main objection.

25 COMMISSIONER FIRESTONE: Your main objection
26 being Government control and no fiscal authority in a
27 Province-wide plan?

28 DR. BAROOTES: Yes, sir.

29 COMMISSIONER FIRESTONE: While this plan has
30 no direct Government control and has its own fiscal in-
dependence; is that your thinking?

leH/je 31 DR. BAROOTES: That is correct, sir. Those
32 are the two main features of it which we have observed



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3 as being different from our Provincial programme.

4 COMMISSIONER FIRESTONE: You also admitted that
5 this Swift Current plan has compulsory features?

6 DR. BAROOTES: Yes, sir.

7 COMMISSIONER FIRESTONE: And it provides for
8 some of the cost of the plan to be paid out of taxation.
9 Do I take it from that that you can visualize circumstances
10 under which a tax supported compulsory plan could be use-
11 ful to the people of a region in the Province of
12 Saskatchewan?

13 DR. BAROOTES: There are many such programmes
14 in operation now that are municipal programmes that from
15 the viewpoint of taxation have compulsory features. I
16 do not know any way in which you can make taxation or
17 raise taxes except by compulsion. I think legislative
18 bodies in this country have always had the right to levy
19 taxes by compulsion.

20 DR. DALGLEISH: May I also say in considering
21 some of the aspects of the Swift Current area and in con-
22 sidering medical service insurance in general we have
23 not discussed changes, any necessary changes in quality
24 of care or in standards of care in any such region as
25 compared with any other region and this would be most
26 important if it is to be considered in any original plan.

27 COMMISSIONER FIRESTONE: Thank you very much.
28 Dr. Dalglish, may I turn now to the Hospital Insurance
29 Programme as it now exists, does that programme cover
30 everybody in Saskatchewan?

DR. DALGLEISH: The programme is compulsory
and only those who have not the money or break the law



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3 do not pay.

4 COMMISSIONER FIRESTONE: And the services are
5 available to everybody in the Province of Saskatchewan?

6 DR. DALGLEISH: Yes.

7 COMMISSIONER FIRESTONE: It is, therefore, a
8 comprehensive, universal and compulsory scheme?

9 COMMISSIONER McCUTCHEON: To everybody who
10 has paid the premium as was pointed out by the Minister
11 yesterday?

12 COMMISSIONER FIRESTONE: It is a universal
13 scheme and it is compulsory, is that correct?

14 DR. DALGLEISH: Yes.

15 COMMISSIONER FIRESTONE: The funds to finance
16 this scheme come in part by payment of a premium and
17 partly out of general revenue, Provincial and Federal
Government, is that correct?

18 DR. DALGLEISH: Correct.

19 COMMISSIONER FIRESTONE: Now, is the Medical
20 Association of Saskatchewan satisfied with the operation
21 of this?

22 DR. DALGLEISH: In general, as we did at the
23 inception of this scheme, we support hospitalization.
24 At the start we recommended possible certain things about
25 this plan which we still think might go to improve it.
26 We do think that after fifteen years we should take a
27 very hard look at it and see if it is serving the best
28 purpose that was intended or originally set up for. In
29 answer to your question we believe it has raised the
30 quality of care for our patients.

COMMISSIONER FIRESTONE: Thank you, that is



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available to everybody in the Province of Saskatchewan?

DR. DALLMAN: Yes.

COMMISSIONER FERGUSON: It is, therefore, a

comprehensive, universal and compulsory scheme?

COMMISSIONER FERGUSON: To everybody who

has paid the premium as was required by the statute.

COMMISSIONER FERGUSON: It is a universal

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DR. DALLMAN: Yes.

COMMISSIONER FERGUSON: The cost to the

this scheme comes in part by payment of a premium and

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COMMISSIONER FERGUSON: Yes, is the federal

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COMMISSIONER FERGUSON: Thank you, that is



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4 a forthright answer and I appreciate it.

5 DR. ANDERSON: I think at the same time that
6 there has been feeling though that in our compulsory
7 hospitalization system that there is an increase in
8 dominion on the part of the Government and an increase
9 in control of our hospitals that may not be entirely
desirable.

10 COMMISSIONER FIRESTONE: Thank you for adding
11 this qualification, you anticipated my next question.
12 The next question was, since hard luck might suggest a
13 number of possible improvements could we turn to your
14 Association and ask you to consider what possible such
15 improvement might be and let us have your views in terms
16 of specific recommendations at a subsequent date in
writing?

17 DR. DALGLEISH: You are the first one that has
18 asked us for this and we would be very glad to give it to
19 you.

20 COMMISSIONER FIRESTONE: Thank you for the
21 assurance. Now, if I may pursue this question a little
22 further. Here we have a plan in the field of hospital
23 care which provides for compulsory features which pro-
24 vides for comprehensiveness, which provides for payment
25 out of general tax revenues. Well now, sir, if your
26 Association is in favour of those principles as being
27 applicable to the hospitalization scheme, what are the
reasons why you would not be in favour of the same
principles applying to medical care service?

28 DR. DALGLEISH: Well, I will start this by
29 saying that the personnel services, the relationship in
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COMMISSIONER FLETCHER: Thank you for raising

this difficult question, you anticipated the next question.

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of specific recommendations as at a subsequent time in

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Association in favor of those principles as being

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DR. FLETCHER: Well, I will start this by

saying that the personal services, the relationship in



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4 medical care between doctor and patient cannot be com-
5 pared to such things as buildings and furniture and other
6 things that go to make up a hospital programme.

7 DR. BAROOTES: Mr. Chairman, you have hit on
8 the crux of our objection, I take it. "What is our ob-
9 jection to compulsion in medical care programme?"

10 COMMISSIONER FIRESTONE: Why are you for com-
11 pulsion of hospitalization and against compulsion in your
12 own field?

13 DR. BAROOTES: I can answer the first thing
14 right away. One is an institution and the other is a
15 person to person relationship. In one sentence that is
16 our answer. We can elaborate on this because we believe
17 this is the heart of our argument.

18 COMMISSIONER FIRESTONE: Would you like to
19 elaborate on this part of your argument because we really
20 ought to understand it and all its implications.

21 DR. BAROOTES: I feel there are others who
22 will also be qualified to add their opinion to this. Our
23 opinion of compulsion is the same as Government control;
24 if we are to set up a monolithic or a monopoly of medical
25 care operated on compulsion it obviously infers with it
26 Government control with others. We look at it from the
27 viewpoint of "Is this the best thing for our patients?"
28 We can also look at it from the viewpoint "Is this the
29 best thing for our doctors?" After all, if our doctors
30 are good our patients should get good care and if our
doctors are bad any amount of money spent badly on bad
doctors is unlikely to result in good care for our patients.

Philosophically we are against compulsion in



medical care between doctor and patient cannot be compared to such things as buildings and furniture and other things that go to make up a hospital programme.

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4 this aspect. We are in favour of compulsion only if it
5 involves a national safety or a community safety, I
6 should say. In the time of war you and I and others of
7 us will submit to compulsion in the Army or in the Navy,
8 we will constrict ourselves to defend today what we wish
9 to enjoy tomorrow. I think that is quite proper. This
10 is not because we favour compulsion but it is a matter
11 of national emergency.

12 In matters of community I am forbidden to
13 drive my car on the highway more than 50 miles an hour or
14 through a red light at the threat of some penalty. This
15 is not to protect me, because society cares not for me,
16 but to protect the other members of my community whom I
17 might injure with my reckless driving.

18 In medical matters exactly the same thing
19 applies. For instance, if I have a communicable disease,
20 an open tuberculosis, I am confined and incarcerated if
21 necessary by law, in a sanatorium. Because I have reached
22 beyond the age of choice I am compelled to be quarantined
23 or isolated to protect the rest of my community from my
24 germs. I do not need to take treatment for my tuberculosis,
25 I can stay in my sanatorium bed and be isolated and ex-
26 pire. In other words, the law is for the community good
27 and not for me.

28 We submit to chlorination of water, the fil-
29 tration of water, the pasteurization of milk for the com-
30 munity and we feel in these matters of compulsion, that
compulsion is necessary, it has to be done not for my
good but for the community good.

If there exists at the present time in Canada



this aspect. We are in favour of compulsion only if it

involves a national safety or a community safety. I

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In matters of community I am forbidden to

drive my car on the highway more than 30 miles an hour or

through a red light at the threat of some penalty. This

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but to protect the other members of my community whom I

might bring with my reckless driving.

In medical matters exactly the same thing

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good but for the community good.

If there exists at the present time in Canada



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3 a national health emergency then we should conscript
4 our doctors to this service but when we have such emi-
5 nent men in my profession as Dr. Penfield, and I should
6 like to read you the words that he gave:

7 "Nowhere in the world is the level of general
8 practice generally superior to that of Canada today."

9 You could take it from another profession,
10 from the words of our former Premier who says it goes
11 without saying we are enjoying a high level of health
12 care through our doctors in Saskatchewan. If there
13 exists in this Country or in this Province at the present
14 time a crisis in health care in this time of the highest
15 standard of living and perhaps the highest standard of
16 health which we have enjoyed in our times, should we
17 jettison a system which without compulsion and without
18 loss of liberty has brought us this far along the road
19 to accept something of compulsion which may or may not
20 give us a better level of health care for our citizens.
21 I am not certain but if we are doing well with the
22 present system that we are enjoying I think we should
23 defend that system of medical care. It has come from
24 the Province that we have today good mortality tables,
25 ever-increasing findings on research and it has been
26 done under a free enterprise system of medicine. That
27 is the philosophy of it. The philosophy of myself as
28 a citizen is a philosophy of being against compulsion
29 unless it is necessary for a common good, a national
30 safety, an emergency. That is the story I have
philosophically. Moreover, I would go a step further
and say that those who came to this Country from foreign



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come in and look at the situation. If there
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from the words of our former Premier who says it goes
"You could take it from another profession,
practice generally superior to that of Canada today."
"Somewhere in the world is the level of general
like to hear you the words that he gave:



lands have found that our forefathers came to this Country not to face compulsion but to avoid compulsion; the white Russian, the Ukranian, the Greek like my father who lived in Asia Minor which was then a Turkish Country and did not wish to submit his children to the Turkish school, the Turkish language and the Turkish principles. You have the Ukranian only who did not come to this great free Country of Canada but to the Prairies, the great free Canadian West. More recently we have had the example of the Hungarians who swam the rivers in Hungary to escape to freedom and who came to this Country, to the great free western part of Canada just as my father did along with so many other forefathers in the West to pound stakes in the C.P.R. Railway, to weather the storms such as you experienced in Winnipeg which I am sure you did not find too pleasant. They matched their sinew and their lives and bodies in a land of freedom. If they were successful they would be rewarded for that success with liberty and any other reward that goes with it and if they did not make it they would be buried with the buffalo and the Indian. When we come to this Country seeking freedom it is incongruous to me that at a later time we should give in to compulsion in matters of our own responsibility. This matter of a right to health is a right to health but with it, like freedom of the press, comes a certain sense of responsibility. A right to health is a liberty but it is also a responsibility for me to provide for my family and my children. If I wish to choose the Crown Life Company and can read the contract and buy it, if I want to have it G.M.S. I can do that.

I have found that our forefathers came to this country not to find a new land but to find a new life. The white Russian, the Ukrainian, the Greek like my father who lived in Asia Minor which was then a Turkish country and did not wish to submit his children to the Turkish school, the Turkish language and the Turkish politics. You have the Ukrainian only who did not come to this area for a country of Canada but to the United States, the great free Canadian West. Your people have had the example of the immigrants who came to this country to escape to freedom and who came to this country to the great free western part of Canada just as my father did along with so many other immigrants in the West to find a new life in the C.N.R. railway, to work for the same such as you experienced in Winnipeg when I was young. I did not find too pleasure. They wanted to be free and their lives and bodies in a land of freedom. If they were successful they would be rewarded for that success with liberty and any other reward that goes with it and it was not too late if they would be free. I was not too late and the Indian. When I came to this country I was free. It is impossible to see that as a later date. I should give to the population in matter of my own responsibility. This matter of a right to life is a right to be born but with it, the freedom of the great, a right to a right of responsibility. A right to a right is a right but it is also a responsibility for me to provide for my family and my children. If I wish to choose the same life I wish to choose the same life and pay it, if I want to have it C.N.R. I can do that.



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3 If you wish to buy you can do that and not be told that
4 this is the only way and the only method by which you
5 can have your health and life insured. This is our story
6 about compulsion. I say this feelingly, because I believe
7 it, and am sensitive about it and I am at least sincere.
8 There are, of course, many other reasons why we oppose
9 compulsion not only for us but for our patients and
10 those are matters of administration that might lower
11 the standards of medical care ultimately; they might not
12 but they might. We hate to jump into the deep end of
13 the pool without finding out first at the other end if
14 the water is deep or cold and go into the shallow end.
15 We think a man has a right if he wants to try individual
16 medical care that M.S.I. is important where a man can
17 walk in off the street. We tried this kind of coverage
18 until 1959 when certain pronouncements stopped our rising
19 enrollment or at least brought it to a standstill. We
20 would like to try these methods and pick the one or five
21 or ten or to have somebody approve a regulatory body
22 and say "This one is good." or "That one is good."
23 but not to compel everybody and say "This shoe is going
24 to fit every foot." There must be a difference among
25 individuals, a difference of need, a difference of depth,
26 a difference of requirement. That is a philosophic at-
27 titude and I am sorry to burden you with so long an ob-
28 servation.

26 COMMISSIONER FIRESTONE: We are very grate-
27 ful to have it. I think I might speak for all the
28 Commissioners when I say we are very much obliged to
29 have the basic understanding of why the medical profession
30



If you wish to pay you can do that and not be told that
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or ten or to have somebody approve a regulatory body
and say "this one is good," or "that one is good."
But not to compel everybody and say "his shoe is going
to fit every foot." There must be a difference among
individuals, a difference of need, a difference of depth,
a difference of responsibility. That is a philosophical at-
titude and I am sorry to burden you with so long an ex-
planation. I think I might speak for all the
Commissioners when I say we are very much obliged to
have the basic understanding of why the medical profession



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3 in Saskatchewan feel so strongly about this particular
4 principle. We are very much obliged to you for explain-
5 ing it to us as fully as you did.

6 Now, if I might proceed from here: as you
7 know, under our Federal system if we are to develop in
8 Canada a national health or national prepaid medical
9 care plan, I say if such a plan were to develop, the
10 Federal Government could make a financial contribution
11 and leaving the methods of development and such to the
12 provinces who have the majority responsibility in the
13 field of health. Now, if such a plan were to evolve
14 leaving it up to each province to decide whether it was
15 to have a compulsory scheme or a voluntary scheme, or,
16 if you prefer, a plan instead of a scheme, but leaving
17 it up to the provinces with the Federal Government making
18 a contribution, would your Association be in favour of
19 such a plan if the principle of voluntary participation
20 were observed in the Province of Saskatchewan? Now, so
21 that you do not misunderstand me, this would still in-
22 volve Government participation in such a plan because
23 obviously the Government contributing a very large portion
24 of the funds they will want to have control over those
25 funds. If we follow the principle of voluntary parti-
26 cipation as against compulsory participation with the
27 Federal Government leaving it up to the provinces to
28 make up its own mind, what would the attitude of your
29 Association be in such a case?

30 DR. DALGLEISH: We would hope in any such
Federal sharing that consideration to the needs, the
health needs of the province would be considered. As



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in Saskatchewan feel so strongly about this particular principle. We are very much obliged to you for explaining it to us as fully as you did.

Now, if I might proceed from hence, as you know, under our Federal system if we are to develop in Canada a national health or national prepaid medical care plan, I say it such a plan were to develop, the Federal Government could make a financial contribution and leaving the methods of development and such to the provinces who have the majority responsibility in the field of health. Now, if such a plan were to evolve leaving it up to each province to decide whether it was to have a compulsory scheme or a voluntary scheme, or, if you prefer, a plan instead of a scheme, in leaving it up to the provinces with the Federal Government making a contribution, would your association be in favour of such a plan in the principle of voluntary participation were observed in the Province of Saskatchewan? Now, so that you do not misunderstand me, this would still involve Government participation in such a plan because

of the funds they will want to have control over those funds. If we follow the principle of voluntary participation as against compulsory participation with the Federal Government leaving it up to the provinces to make up its own mind, what would the attitude of your association be in such a case?

DR. DUNCAN: We would hope in any such health needs of the province would be considered, as



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3 we have suggested today the most urgent needs are in the
4 area of first, mental health followed by a close second,
5 the aged and chronically ill, rehabilitation. Then,
6 among the population in general who are in the low ec-
7 onomic phase of society, those people with low income
8 and those in need, we would want to ensure that monies
9 in depth for the people who are needy would be obtained.
10 We would hope that long before consideration be given to
11 those who are well able to provide for their own health
12 services that, long before that, money should be supplied
13 in the areas of need.

14 COMMISSIONER FIRESTONE: We are very much ob-
15 liged to you for setting out the priorities. You have
16 done this before and you have reiterated and we are very
17 grateful to you but, as you realize, this Commission is
18 charged with the responsibility of making recommendations
19 in all fields as well as setting out priorities.

20 And then, when we come to work out proposals,
21 and if for example a proposal were made to the Canadian
22 Government, I say for example, I don't know what will be
23 the case, but if such a proposal were made, and the
24 Government of the day were to adopt it, leaving it to the
25 Provinces to make the decision whether it is a voluntary
26 or a compulsory scheme, would your Association be in
27 favour of such a scheme? Would you support it if it were
28 on a voluntary basis?

29 DR. DALGLEISH: Mr. Commissioner, I don't
30 quite understand in what depth you are suggesting help,
subsidies to all?

COMMISSIONER FIRESTONE: Well, sir, I am

area of first, mental health followed by a close second,
the aged and chronically ill, rehabilitation, then,
among the population in general who are in the low so-
ciologic phase of society, those people with low income
and those in need, we would want to assume that mental
in health for the people who are needy could be obtained.
We would hope that some persons could obtain as given to
those who are well able to provide for their own health
services that, they become a part, really should be supplied
in the area of need.

It is for you to get out of the territories, you have
done this before and you have not failed and we are very
grateful to you but, as you say, it is a commission to
operate with the responsibility of making recommendations
in all fields as well as social, and economic.

And then, when we come to our proposals,
and it for example a proposal, we are to the Government
Government, I say for example, I don't know what will be
the case, but if such a proposal were made, and the
Government of the day were to adopt it, I would like to see
provisions to make the decision whether it is a voluntary
or a compulsory scheme, well, your decision as to
favour of such a scheme, we do not support it if it were
on a voluntary basis.

Dr. Macdonald: Mr. Commissioner, I don't
quite understand in what depth you are expecting help,
subsidies to all?



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3 talking of a comprehensive medical care service programme
4 to which the Federal Government would contribute a certain
5 amount of money, but with the Province developing the
6 programme as it sees it best in the light of the require-
7 ment of its people, in the light of the willingness of
8 the people to participate, and if it were left to the
9 discretion of that Government to make the choice. Pre-
10 sumably, if it were a voluntary programme, the Federal
11 Government would state conditions, for example saying
12 that at least 75 percent to 85 percent of the population
13 would have to be covered before it would make a contri-
14 bution, but in view of the feature of it being voluntary
as distinct from compulsory, would you support it?

15 DR. ANDERSON: No, I would want to know, Mr.
16 Chairman, whether the subsidy would apply to everybody,
17 or to these groups which we feel have the greatest need.

18 COMMISSIONER FIRESTONE: As I said, sir, the
19 subsidy would provide for a comprehensive and compulsory
20 medical health care programme, to be administered in the
21 Province, working out the best system for the people,
22 but using the voluntary concept as against the compulsory
concept?

23 DR. DALGLEISH: Mr. Commissioner, maybe we
24 don't seem to be answering this very alertly, but it is
25 a new question to us. Might we say that we wonder what
26 benevolent Government might wish to subsidize anyone who
27 is well able financially to select and maintain his own
medical care.

28 COMMISSIONER FIRESTONE: Dr. Dalglish, I
29 didn't suggest that. If I may state my question that the
30



to which the Federal Government would contribute a certain amount of money, but with the Province developing the programme as it sees fit in the light of the requirements of its people, in the light of the willingness of the people to participate, and if it were left to the discretion of that Government to make the choice. Presumably, if it were a voluntary programme, the Federal Government would offer conditions, for example saying that at least 85 percent of the population would have to be covered before it would make a contribution, but in view of the fact that it is being voluntary as distinct from compulsory, would you support it?

MR. ANDERSON: No, I would want to know, Mr. Chairman, whether the subsidy would apply to everybody, or to those groups which we feel have the greatest need.

MR. TINKER: As I said, sir, the subsidy would provide for a comprehensive and compulsory medical health care programme, to be administered in the Province, working out the best system for the people, but using the voluntary concept as against the compulsory concept.

don't seem to be answering this very exactly, but it is a new question to me. Might we say that we wonder what benevolent Government might wish to subsidize anyone who is well able financially to select and maintain his own medical care.

I didn't suggest that. If I may state my question that the



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4 Federal Government would be prepared to make available
5 a sum of money to the Provincial Government of your
6 Province, saying that this money, as long as certain
7 conditions as set out are met, certain standards are met,
8 and a certain proportion of your population is covered,
9 that this fund be used to provide a comprehensive and
10 universal medical care programme, either on a voluntary
11 or on a compulsory basis, as the Provincial Government
12 sees fit, would you support such a programme?

13 DR. BAROOTES: May I try to interpret this
14 and perhaps give you the opinion of the College of Surgeons
15 and Physicians. I would feel that the Federal Government
16 is going to pay monies either in a lump sum or in some
17 way, to the Provincial Government. These would be what
18 we call contingency grants, or another word is used --

19 COMMISSIONER FIRESTONE: Conditional grants.

20 DR. BAROOTES: Conditional grants, and these
21 conditional grants in Saskatchewan would be based on
22 certain conditions which are, in your own expression,
23 that you have coverage in Saskatchewan that our Govern-
24 ment chooses to make this voluntary, is that correct?

25 THE CHAIRMAN: I am going to try to interpret
26 the question for both of you, if I may.

27 COMMISSIONER FIRESTONE: Thank you, Mr.
28 Chairman. It will be most helpful.

29 THE CHAIRMAN: What Dr. Firestone is saying
30 is that provided it should be recommended that there is
to be a comprehensive medical service programme for
Canada as a whole, that is the initial, that is your
no. 1 step. The second step of that being that the



a sum of money to the Provincial Government of your Province, saying that this money, as long as certain conditions are set out are met, certain standards are met, and a certain proportion of your population is covered, that this fund be used to provide a comprehensive and universal medical care programme, either on a voluntary or on a compulsory basis, as the Provincial Government sees fit, would you support such a programme?

MR. GIBBS: I try to interpret this

and perhaps give you the opinion of the College of Surgeons and Physicians. I would feel that the Provincial Government is going to pay out of their own funds a sum of money in some way, to the Provincial Government, and these would be what we call contributing funds, or a fund would be used -

MR. GIBBS: Conditional grants, and these conditional grants in Saskatchewan would be based on certain conditions which are, in your own expression, that you have conveyed in Saskatchewan that our Government chooses to make this voluntary, is that correct?

THE CHAIRMAN: I am going to try to interpret the question for both of you. I say

Chairman, it will be most helpful.

is that provided it should be recommended that there is to be a comprehensive medical service programme for Canada as a whole, that is the initial, that is your no. 1 step. The second step of that being that the



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3 Federal Government would then make available to the
4 Province, on some basis, a sum of X dollars, to be used
5 subject to certain conditions applicable to all of Canada.
6 You see, the conditions must be applicable to the ten
7 provinces. Those are the minimum conditions, that is if
8 70 percent have to be covered, there would be 70 percent
9 in Saskatchewan and 70 percent in Newfoundland.

10 DR. BAROOTES: Or better.

11 THE CHAIRMAN: That these conditions would
12 have to cover the whole Country, and having done that,
13 laid down these basic conditions, whatever they might be,
14 would you in those circumstances favour a programme which
15 as part of those conditions states that the Province
16 might use its money, might use this money that is given
17 to it, either in furtherance of a voluntary scheme, or
18 of a compulsory one?

19 DR. BAROOTES: I would interpret the attitude
20 of our College at the present time, and without further
21 study, and we will give it further considered opinion,
22 that if these conditions were met, that our answer would
23 probably be yes, with these conditions that in our
24 Province, and I presume our Province would still have its
25 B.N.A. jurisdictional health features, that in our Province
26 before the doctors as they present feel would accept such
27 a programme, that (a) it would have to include those
28 groups which we categorically call indigent, it would have
29 to include with no cost to them the low income groups,
30 that we have outlined, and thirdly it would have to in-
clude the chronically ill.

Then, the next thing is that the rest of the



Government would then make available to the
provinces, on some basis, a sum of \$1 billion, to be used
subject to certain conditions of reference to all of Canada.
You see, the conditions must be applied to the ten
provinces. These are the minimum conditions, that is if
75 percent have to be covered, there would be 75 percent
in Saskatchewan and 75 percent in Newfoundland.

Have to cover the whole country, not just in some part.
said down there in the conditions, whether they might be
would you in the circumstances favour a program which
as part of these conditions states that the Province
might not be covered, might not be covered that is over
to, either in form or in substance, in
of a compulsory order.

Mr. BAKER: I would suggest that the conditions
of one billion to the provinces, not without further
study, and we will give it further study, and we will
that if the conditions were met, that we can answer would
probably be yes, and these conditions that in one
Province, and I suppose the Province would still have its
B.I.N. jurisdictional, health features, that is one thing
before the doctors as they present fact would accept such
a program, that (a) would have to include those
grades which we are now calling "elementary", it would have
to include with no cost to the Province, it would have
that we have outlined, and finally it would have to in-
clude the children's all.

That, the next thing is that the rest of the



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4 self-sufficient population, because the rest of the popu-
5 lation is self-sufficient, should choose to buy their
6 insurance, and that they reach that 70, 90, or 80 percent
margin, and then we would go along with it.

7 One further stipulation that I would inter-
8 pret, is that the Government regulation should be by a
9 regulatory body, which regulatory body would only tell us
10 --

11 THE CHAIRMAN: Now, I am going to stop you,
12 because you have gone right off the track. The key part
13 of the question was the last part that I thought I put
14 with such deliberation, that having these conditions,
15 would you be willing to accept a Provincial programme,
either on a voluntary basis or on a compulsory basis?

16 DR. BAROOTES: One or the other?

17 THE CHAIRMAN: One or the other, at the option
18 of the Province.

19 DR. DALGLEISH: Mr. Chairman, you may think
20 we are overly cautious in these parts but we would like to
21 take this and study it, and give you an answer later. I
22 think the answer would probably be yes, but it is a new
question.

23 THE CHAIRMAN: Let me put it so that you may
24 fully appreciate it. You repudiate compulsion for your-
25 self here in Saskatchewan, for your people here in
26 Saskatchewan, but would you be willing to see compulsion
imposed on the people of Ontario?

27 DR. BAROOTES: No, sir.

28 THE CHAIRMAN: Well, isn't that what we have
29 been asking you for the last ten minutes?
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4 DR. BAROOTES: Well, we have misinterpreted
5 your question.

6 COMMISSIONER FIRESTONE: Well, would you not
7 feel sir --

8 DR. BAROOTES: Did you say either or. If it
9 were voluntary, I think we would accept it.

10 COMMISSIONER FIRESTONE: Yes, but sir, if
11 we leave the choice to the people in each Province, after
12 all, we have ten provinces, and if the people in Ontario
13 want it one way and the people in Newfoundland want it
14 compulsory, and the people in Saskatchewan want it vol-
15 untary, would you object to the people in Newfoundland
16 having compulsory and Saskatchewan voluntary?

17 DR. BAROOTES: If they chose by their own
18 volition to have this type of programme, I am not going
19 to stand in their way.

20 COMMISSIONER FIRESTONE: Then the answer to
21 the question the chairman and I have given to you is yes,
22 if they were given the choice you would have no objection
23 to the choice being given to each province?

24 DR. BAROOTES: I see your question now. Each
25 province has it their own way?

26 COMMISSIONER FIRESTONE: That is right.

27 DR. BAROOTES: As a matter of fact, this
28 hospitalization in Ontario today, it is not compulsory.

29 COMMISSIONER FIRESTONE: Yes, this is how we
30 arrived at it. This is the crux of the problem. We then
understand the answer to the question the chairman and I
have put is yes.

DR. BAROOTES: We would not want to be in



DR. BARON: Well, we have misinterpreted

COMMISSIONER: Well, would you not

DR. BARON: Do you say either or. If it

were voluntary, I think we would accept it.

COMMISSIONER: Yes, but sir, if

we leave the choice to the people in each province, after

all, we have ten or twelve, and if the people in Ontario

want it one way and the people in Newfoundland want it

compulsory, and the people in Saskatchewan want it vol-

untary, would you object to the people in Newfoundland

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DR. BARON: If they choose by their own

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if they were given the choice you would have no objection

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COMMISSIONER: That is right.

DR. BARON: As a matter of fact, this

responsibility in order to today, it is not compulsory.

COMMISSIONER: Yes, this is how we

arrived at it. This is the crux of the problem. We then

understand the answer to the question the chairman and I

have put it to

DR. BARON: we would not want to be in



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3 favour of the interpretation of Saskatchewan choosing
4 a compulsory programme.

5 THE CHAIRMAN: No, but just supposing Saskat-
6 chewan should choose a voluntary programme?

7 DR. ANDERSON: My feeling, Mr. Chairman, is
8 this, that after all we are a part of the profession of
9 Canada and we are a part of, you might almost say the
10 religion of medicine. We are not self-sufficient, we
11 are not just Saskatchewan doctors. We are Canadian
12 doctors. We are world doctors. Now, we do not want to
13 see this come about, a compulsory scheme in Saskatchewan.
14 My feeling is that we do not want to see it come for any
15 other area, Saskatchewan, Ontario, Newfoundland, or any
16 other place, because we feel that it will lead to a
17 deterioration in the quality of medicine, and this is
18 not good for any part of Canada.

19 COMMISSIONER FIRESTONE: But you would feel
20 that the people in Saskatchewan do not wish to tell the
21 people in Newfoundland how to live and run their show.
22 This is the essence of a Federal system.

23 DR. ANDERSON: You say people?

24 COMMISSIONER FIRESTONE: I take it you are
25 speaking for the people of the Province?

26 DR. ANDERSON: No, I was speaking for the
27 profession.

28 DR. DALGLEISH: I think you have been very
29 patient, Mr. Chairman and Mr. Commissioner. We think
30 it has many implications, and we would like to consider
it further, and we will let you have our views.

DR. BAROOTES: Could the question be sent



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4 by your Secretary to us, as you framed it?

5 COMMISSIONER FIRESTONE: May we suggest that
6 you obtain a full transcript of what has transpired to-
7 day, so that you may see it in the full context. And
8 may I say in conclusion, Dr. Barootes, that you and
9 your associates have been very helpful, and we now have
10 a much better understanding of the point of view held
11 by the medical profession in Saskatchewan, and thank you
12 very much.

13 THE CHAIRMAN: We will now take a short recess.

14 ---A SHORT RECESS:

15 ---ON RESUMING:

16 THE CHAIRMAN: Ladies and gentlemen, if you
17 will come to order we will proceed. Now, Dr. Dalgleish,
18 I have one further question to put to you. It is hypo-
19 thetical in nature. If a comprehensive medical programme
20 should be recommended, and say one of the voluntary non-
21 profit organizations chosen as the vehicle to administer
22 the programme say in Saskatchewan, that is to handle the
23 disbursement of the monies payable to health service
24 personnel, including doctors, would the College of
25 Physicians and Surgeons of Saskatchewan have any object-
26 ion to the one vehicle, the one organization, admini-
27 strative body, handling the disbursement, the payment
28 for services to physicians, dentists, druggists, opticians,
29 and other health personnel, such as chiropractors, and
30 osteopaths, and so forth?

DR. DALGLEISH: Well, Mr. Chairman, I think

by your liberality to us, as you framed it?

GOVERNMENT HIRSHMAN: May we suggest that

you obtain a full transcript of what has transpired to-

day, so that you may see it in the full context. And

may I give you a suggestion, Dr. Hirschman, that you and

your associates have been very helpful, and we now have

a much better understanding of the point of view held

by the medical profession in Washington, and thank you

for that. We will now take a short recess.

---A SHORT RECESS---

THE CHAIRMAN: Now, Dr. Hirschman, if you

will come to a table in the rear of the room, Dr. Hirschman,

I have one question to ask you. It is hypo-

thetical, but I would like to ask you if the military non-

profit organizations are opposed to the right to administer

the medical care in Washington, that is to handle the

disasters? Is the medical service to health service

personnel, and if so, would the College of

Physicians and Surgeons of Washington have any objec-

tion to the medical care, the medical service, admini-

strative body, handling the disaster, the payment

for services to physicians, dentists, druggists, hospital

and other health personnel, such as chiropodists, and

osteopaths, and so forth?

DR. HIRSHMAN: Well, Mr. Chairman, I think



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4 that our prepaid plans are so constituted that they
5 could provide a wide range of services through subsidy.
6 For example, all aspects of health service that is
7 ordered by doctors. I would gather --

8 THE CHAIRMAN: I take it it is a new question.
9 If you wish to reserve your answer for consultation
10 with the College, it would be quite appropriate.

11 DR. ANDERSON: Mr. Chairman, could I ask what
12 you mean by comprehensive, because there are sometimes
13 two meanings to the word. Do you mean the range of
14 benefits?

15 THE CHAIRMAN: No, comprehensive in coverage,
16 including dentists, prepaid drugs.

17 DR. BAROOTES: But you don't mean comprehensive
18 in terms of universality, which some people use?

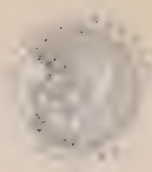
19 THE CHAIRMAN: No.

20 DR. DALGLEISH: I understood that, sir, and
21 the answer is that our prepaid plans, with some adjust-
22 ments, could handle the general services you have out-
23 lined, at least those aspects which physicians prescribe
24 for their patients, which does include drugs and dentists'
25 services, and so on.

26 THE CHAIRMAN: Do you stop there?

27 DR. DALGLEISH: Well, with regard to osteopath
28 and chiropractic services, our feelings as a College are
29 that these other areas that I have mentioned --

30 THE CHAIRMAN: I am not asking for a philo-
sophical discussion on that. Chiropractors, osteopaths,
and others, are legally entitled to practise their
professions in this Province, are they not?



that our proposed plans are so constituted that they
could provide a wide range of services through subsidy.
For example, all aspects of health service that is
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two meanings for the word. Do you mean the range of
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for their patients, which does include drugs and dentists
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DR. GILLESPIE: Well, with regard to osteopath
and chiropractic services, our feeling as a College are
that these other areas that I have mentioned --

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sophical discussion on that. Chiropractors, osteopaths,
and others, are legally entitled to practise their
professions in this Province, are they not?



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4 DR. DALGLEISH: Yes.

5 THE CHAIRMAN: I am just saying, do you think
6 that the one administrative body could administer the
7 funds to pay all these divergent services?

8 DR. DALGLEISH: Well, the answer to that is
9 they could but they are not in a position to provide
10 chiropractors or osteopaths, to cover their services.

11 THE CHAIRMAN: I will put it this way. You
12 could but you wouldn't?

13 DR. BAROOTES: Mr. Chairman, there is one other
14 aspect of it, besides that, that would make us feel at
15 present under, and I will give our considered opinion
16 to you in writing, that is what you have described as
17 one administrative agency would not meet entirely with
18 our approval. We would like to see some competition in
19 the fields.

20 THE CHAIRMAN: But I am just putting it to
21 you, if that should be the programme that might be sug-
22 gested. You see, we have to put it --

23 DR. BAROOTES: You would have to consider the
24 chiropractor and the non-medical, there are --

25 THE CHAIRMAN: Chiropodists?

26 DR. BAROOTES: They are included in. They
27 are quite acceptable.

28 THE CHAIRMAN: Is it a question that you wish
29 to choose the company from which you would in common
30 draw your compensation?

DR. DALGLEISH: Well, Mr. Chairman, we have
given the answer no as of today, but we will take this
under advisement, and we will pursue it further.



THE CHAIRMAN: Very well.

DR. DALGLEISH: Mr. Chairman, sir, if I am in order, I would like to ask a question about the matter we were discussing before coffee.

THE CHAIRMAN: Your condition of course is hard to accept, because some of us may not have had coffee, but we will give you the floor.

DR. DALGLEISH: Well, Mr. Firestone, I was wondering sir, when you described subsidy from Federal funds, were you thinking of providing these funds directly to say organized Government in these areas, or did you anticipate by any chance subsidies to existing insurance mechanisms in those provinces?

COMMISSIONER FIRESTONE: Mr. Chairman, I would be very happy to answer the question, but I hope that in answering it we do not create a precedent by the Commissioners being asked questions from the floor, but without creating this precedent, I would be very happy to elaborate what I had in mind. You will recall, sir, that the Provincial Government of Saskatchewan has suggested that the Federal Government make a contribution of 60 percent to a Provincial plan. Now, whether such a contribution would be 60 percent or 50 percent, but a certain amount will be made available, hypothetically speaking, under a national plan, I think under our Federal Constitution the primary responsibility in the field of health rests with Provincial Government, all the Federal Government can do, it can make these funds available to the Provincial Governments to develop the best plan they see fit for their province. Does that



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answer your question, sir?

DR. DALGLEISH: Yes, Mr. Chairman, with this regard, this is in explanation of the question that we were to consider, when I was asked the question I said the answer would probably be yes; however, I don't think I should make a comment. It is something that we are going to consider, and let you know about, and I would like the question just to be a no answer at the present time.

THE CHAIRMAN: Well, we cannot -- the moving hand writes, and having written we don't expunge from the record.

DR. DALGLEISH: No, but the same moving hand sir must still be writing.

THE CHAIRMAN: Yes. I thought you wanted to change the answer to no?

DR. BAROOTES: Well, when we have consulted among ourselves --

THE CHAIRMAN: You wanted to give the additional answer of no?

DR. BAROOTES: Yes, when we have consulted among ourselves, we realize now that one can speak as a profession, but not speak for the people of a province, sir, and as a professional body, the College of Physicians and Surgeons would not support such a programme of a compulsory nature in this Province or in any other province, for that matter, so that our answer would have to be, Professor Firestone, as far as I can see, no.

COMMISSIONER FIRESTONE: Without wanting to continue this discussion, since you have taken the question under advisement, will you please recall that



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3 the question offered a choice between voluntary and
4 compulsory. You have only answered the question with
5 respect to the compulsory feature on a temporary basis
6 I might say, and not the question with respect to the
7 choice between compulsion and voluntary, as the chairman
8 explained it to you, and perhaps, sir, we may leave
9 this subject on the basis that you will give further
10 consideration, and you will let us have your considered
11 views, taking into account the full record of the dis-
cussion as it has taken place this afternoon?

12 DR. DALGLEISH: Yes, we will.

je 13 COMMISSIONER McCUTCHEON: Dr. Dalgleish, in
14 answer to a question earlier you agreed to put your views
15 in writing on the hospital services plan in this province
16 to the Commission?

17 DR. DALGLEISH: Yes.

18 COMMISSIONER McCUTCHEON: In your brief on
19 page 37 -- and we had some slight discussion on this
20 earlier when Dr. Van Wart was talking to you -- you make
21 the statement, "Our experience with the Saskatchewan
22 Hospital Services Plan confirms our concern -- for the
23 past two years, hospitals have not been allowed, due to
24 financial restrictions..." -- I assume those are res-
25 trictions imposed by the Province -- "...to expand ex-
26 isting services or to introduce new services." We didn't
27 get any examples of this, as I recall it earlier, and we
28 didn't get what I consider very satisfactory examples
29 of any reduction in services. Could you devote some
30 attention to that, and if there are such examples let
us have them specifically.



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DR. DALGLEISH: Mr. Commissioner, we shall be glad to do so.

DR. BAROOTES: You want that in writing?

COMMISSIONER McCUTCHEON: In writing?

THE CHAIRMAN: In writing, submitted through the secretary to our Ottawa address.

Now, gentlemen, we want to thank you for being here, for subjecting yourselves to the scrutiny of the Commission, and for giving us your views, and all of this, of course, will go into the whole area we will have to consider before we bring in our report. Thank you very much; you have been very helpful.

DR. DALGLEISH: Mr. Chairman, on behalf of the profession may I express our appreciation for this opportunity and your courtesy and interest in our problem.



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THE CHAIRMAN: The next submission is by Miss Grace Stewart, who is presenting a brief as a private citizen.

SUBMISSION OF MISS GRACE STEWART

MISS STEWART: Mr. Chairman and members of the Royal Commission on Health Services I would first like to thank this Commission for extending to individuals in all walks of life, the privilege of presenting a brief.

A plan to meet the needs of the Canadian people for health services will affect every citizen. How it will affect them, whether it will be a plan that will place a limitation on freedom or one that will promote freedom and responsibility, will depend on whether, they, as individuals, are aware of the almost imperceptible danger to personal freedom, in the acceptance of ideas and procedures that promise security and welfare to all by control of the individual, and whether, they make this Commission aware of that danger.

The purpose of this brief, which I have prepared, is to be a voice for individual freedom. The intent is to review the basic principles of our Constitution, so that the need for health services may be placed in its proper perspective, and to recommend a plan to assist those in need, in that field in which the government has a duty.

Just as the government has a duty in the one field, where the rights of the community and society as a whole are concerned, so has it a responsibility to



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Miss Grace Stewart, who is presenting a paper as a private citizen.

COMMISSION OF MISS GRACE STEWART

MISS STEWART: Mr. Chairman and members of

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A plan to meet the needs of the Canadian people for health services will affect every citizen. Now it will affect them, whether it will be a plan that will place a limitation on freedom or one that will promote freedom and responsibility, will depend on whether, they, as individuals, are aware of the almost imperative duty to demand freedom, in the acceptance of ideas and procedures that promise security and welfare to all of Canada of the individual, and whether, they make this Commission aware of that danger.

The purpose of this paper, which I have prepared, is to give a voice for individual freedom. The individual is the basic principle of our Constitution, and that the need for health services may be placed in the proper perspective, and to recommend a plan to secure those in need, in that field in which the government has a duty.

Just as the government has a duty in the one field, where the rights of the community and society as a whole are concerned, so has it a responsibility to



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3 protect a minority and restrain a majority in the field
4 where the individual is concerned.

5 It is argued today that because a certain
6 measure is deemed, in the opinion of some, to be for the
7 good of the community, it is a community right and every-
8 one should be compelled to accept it.

9 A review of the history of civilization and the
10 interpretation of the purpose of government, as defined
11 by John Locke, who in his essay on Civil Government, be-
12 came the formulator of constitutional law and democratic
13 processes as we know them, reveals that the principle
14 of democracy imposes a definite line between where the
15 government may go in the performance of its duty and where
16 the individual may reign as sovereign. It does not re-
17 veal any instances whereby the rights of the individual
18 (as defined) should be over-ruled for the good of the
19 community.

20 The difference between a Democratic Govern-
21 ment and a Welfare State, is that under a free govern-
22 ment the individual has the right to frame the plan of
23 his life to suit his character, within the fundamental
24 laws of the country, and to develop his facilities to
25 the fullest extent possible, while under State control,
26 the government sets the goal and moulds the individual
27 to a standard type to conform to the pattern which the
28 state believes is good for everyone.

29 If a government were to place an advertise-
30 ment in our newspapers, which stated that because the
government deemed it necessary for the good of the
people, certain measures would be enforced and from a



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3 certain date, all citizens, would be required to conform
4 to this law, we would be up in arms right away, because
5 we would recognize that this was not democratic procedure.

6 But, when the means used to attain this very
7 same end, are camouflaged by being presented to the
8 public in the form of a right or as progress, most of us
9 take these statements, at face value and do not bother
10 to define what the end means.

11 I do not believe that the need for health
12 services is as large a problem as it is claimed to be,
13 by the proponents of Compulsory Government Medical Health
14 Schemes. I believe that it has been exaggerated out of all
15 proportion for political purposes.

16 I suggest it is not because of the need of
17 the people for health services that the Government of
18 Saskatchewan has passed legislation to enforce a compul-
19 sory medical scheme, but because of a desire to change
20 our democratic way of life, and to establish a state-
21 controlled society. The fact that this Government has
22 completely ignored the people of Saskatchewan who do not
23 want this compulsory plan, and after exaggerating out of
24 all proportion the need for health services of a small
25 percentage refused to accept or consider plans that have
26 been submitted to assist those few shows they are not
27 concerned about finding the answer to this problem, but
28 of having a society of controlled socialist ideas. The
29 people of Saskatchewan are not poorly dressed, nor do
30 they live in poor homes. While they may not all have the
latest improvements in homes, most of them have the
necessary ones, such as radios, refrigerators, cars and



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3 washing machines. Last year the people of Canada spent
4 some \$60,000,000 on toys. This is a reflection of pros-
5 perity, not need.

6 While I sympathize with those who, because of
7 misfortune or circumstances may have incurred debts be-
8 cause of ill health, I doubt very much if anyone in Canada
9 has done without, or been deterred from seeking health
10 services because of lack of money to pay for them. I
11 would suggest, that if anyone is suffering through lack
12 of money to pay for services, it is the doctors, and they
13 are not complaining.

14 Almost half the population of Canada are in-
15 sured in some form of Voluntary prepaid Medical Insurance
16 scheme. Many other citizens do not prepay their health
17 costs but prefer to pay for them as they need them. To
18 ask these citizens to give up their established way of
19 life and enter a compulsory government controlled plan is
20 to penalize them for being self-supporting and to weaken
21 the moral fibre of the individual.

22 A Compulsory Government Medical Insurance
23 Scheme does not fit the structure of a democratic country,
24 since its purpose is alien to the principle of freedom.
25 I object, very strongly, to being compelled to enter
26 such a scheme, here in Saskatchewan. My objections are
27 based on the fact that it is an infringement on personal
28 liberty and a wedge in the door to a welfare state.

29 I question the right of the Saskatchewan
30 Government to make me assist in paying for the health
services for those in need by compelling me to enter a
Government-controlled insurance plan which is going to

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some \$80,000,000 on toys. This is a reflection of the

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4 cost me \$11. more than my voluntary medical insurance
5 plan does. It is the Provincial Government's responsi-
6 bility to assist those in need. I have fulfilled any
7 responsibility I may have in this respect when I pay
8 taxes. The Honourable Mr. Davies said yesterday morning
9 in reply to a question that the Province has the right to
10 refuse to enter a national health scheme if it sees fit.
11 I believe I have equal right as a citizen to refuse to
12 enter a compulsory Government medical scheme if I see fit.
13 If we are to be a nation of healthy people it is first
14 important we be a healthy individual.

15 The objective of a plan to meet the needs of
16 the Canadian people for health services must be to build
17 up that which is weak or low and not to tear down that
18 which is built up.

19 The plan should be directed to that group who
20 are in need of assistance because of circumstances rather
21 than to those who have not availed themselves of the ser-
22 vices that are available, because they have not placed
23 health needs in an important place in their budget.

24 Assistance in this form would be a brick in the
25 building process of the nation, the same as Family Al-
26 lowances, Old Age Pensions, Assistance to the Blind and
27 the Disabled.

28 Priority in the field of health is, I believe
29 being given to diseases of major importance. While I have
30 made a suggestion that grants be made available to two of
the major diseases, and which are of major importance,
(that is the suggestion in parts of my brief) the Canadian
Arthritis and Rheumatism Society and the Canadian Heart



cost as \$11. more than my voluntary medical insurance plan does. It is the Provincial Government's responsibility to assist those in need. I have fulfilled my responsibility I may have in this respect when I pay taxes. The Honorable Mr. Davies said yesterday morning in reply to a question that the Province was the right to refuse to enter a national health scheme at all cost. I believe I have equal right as a citizen to refuse to enter a comprehensive Government national scheme if I see fit. If we are to have a nation of healthy people it is the responsibility of the Government.

The object of this plan to meet the needs of the Canadian people for health services must be to build up that which is healthy and not to tear down that which is unhealthy.

The plan must be directed to that group who are in need of a health service or other services rather than to those who have not availed themselves of the services that are available. They have not given health needs in an important sense in our present assisted in this form would be a shock in the

while we progress at the nation, the same as Family Allowances, Old Age Pensions, Assistance to the Blind and the Blind.

Priority in the field of health is, I believe, being given to diseases of major importance. While I have made a suggestion that grants be made available to two of the major diseases, and which are of major importance, that is the suggestion in part of my brief the Canadian Association and Rheumatism Society and the Canadian Heart



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4 Association, I have done so with the acknowledgment that
5 I am not fully aware of the extent of government parti-
6 cipation by way of grants in these two fields.

7 I do most strongly request as my right under
8 the Canadian Bill of Rights, that legislation enacted to
9 permit fluoridation of public water supplies be rescinded
10 and that the problem of dental health be met by a demo-
11 cratic method.

12 In Bill C.79, Paragraph 2(a) one of our
13 guaranteed rights is security of the person. It is
14 therefore my right to contact my doctor or dentist if I
15 have an ailment and to obtain a prescription from them
16 prescribed for me as an individual. I have a copy here
17 of an amendment to the Public Health Act in Saskatchewan,
18 which I will leave with the Commission as an exhibit.
19 This amendment gives the Minister of Health in Saskat-
20 chewan unlimited and undefined powers to treat the water
21 supply. He has the power to treat it chemically, electri-
22 cally, mechanically or otherwise. I believe that this
23 power is an infringement on personal freedom. If the
24 Minister of Health deems it advisable, he may enact
25 legislation to give us iron or sulphur or even tranqui-
26 lizers through the water supply. I am not suggesting
27 that the Honourable Minister would, but I am bringing
28 to the attention of this Commission that the first pur-
29 pose and origin of Government was to protect us against
30 anyone or any group having the power or freedom to do
this.

With the above reservation, I believe that
health services for the people of Canada are being



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3 administered by the Department of National Health and
4 Welfare in a form that is sound and in a manner in keep-
5 ing with the principles of democracy.

6 THE CHAIRMAN: Thank you, Miss Stewart. You
7 have exercised your right as a citizen to come forward,
8 and your views will be duly considered.

9 Now, so that we may consider them with some
10 more knowledge of your own position, are you a nurse --
11 or, what is your occupation?

12 MISS STEWART: I am a bookkeeper.

13 THE CHAIRMAN: You are speaking solely from
14 the position of a citizen and not from any particular
15 branch of medicine or health services?

16 MISS STEWART: As an individual.

17 THE CHAIRMAN: Thank you very much. You seem
18 to have a high regard for Locke?

19 MISS STEWART: Yes, I do.

20 THE CHAIRMAN: Do you concede that there may
21 well have been some changes in the notion of what Govern-
22 ment may do in the Twentieth Century as distinguished
23 from the time that Locke lived, which I think was the
24 Eighteenth Century, wasn't it?

25 MISS STEWART: Yes. No, I don't; I concede
26 there may have been some opinions that it should be
27 changed, but I don't concede that the principles that
28 the Government was based on then are basically any dif-
29 ferent now, or should be. They are the foundation of
30 democracy.

THE CHAIRMAN: Thank you very much, Miss
Stewart.



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more knowledge of your own position, and you a nurse --
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the position of a citizen and not from any particular
branch of medicine or health service?
MISS ST. MART: As an individual.

THE CHAIRMAN: Thank you very much. You seem
to have a high regard for books.
MISS ST. MART: Yes, I do.

THE CHAIRMAN: It was wonderful that there may
well have been some changes in the action of what govern-
ment may be in the Government's history as it has been
from the time that we first began I think was the

MISS ST. MART: Yes, I think I should

there may have been some opinions that it should be
changed, but I don't consider that the principle that
the Government is based on then has basically any dif-
ferent now, or should be. They are the foundation of
democracy.

THE CHAIRMAN: Thank you very much, Miss

St. Mart.

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

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---EXHIBIT NO. 81: : Submission of Miss Grace Stewart.

---EXHIBIT NO. 81A: Copy of the Public Health Act of
Saskatchewan and amendment thereto,
filed by Miss Stewart.

MISS STEWART: Thank you very much for giving
me the opportunity to present my brief.



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SUBMISSION OF THE SASKATCHEWAN ASSOCIATION FOR
RETARDED CHILDREN

APPEARANCES:

DR. A.E. BUCKWOLD

DR. A. ROEHER

MR. W.J. DOLAN

---EXHIBIT NO. 82: Brief of the Saskatchewan Association
for Retarded Children

DR. BUCKWOLD: Mr. Chairman and members of
the Commission, may I introduce my associates: Dr. Allan
Roeher and Mr. John Dolan, who is President of the
Saskatchewan Association for Retarded Children and Adults.

THE CHAIRMAN: I am very happy to have Dr.
Roeher and Mr. John Dolan who is an old friend of many
years.

DR. BUCKWOLD: Mr. Chairman and members of
the Commission: in presenting this brief the Association
would like to say we adhere to the fundamental principle
that services and programmes for mentally handicapped
children should differ from those offered any child
only as they relate to very special needs and further
these services and programmes should wherever possible
and wherever practical be developed within the framework
of presently existing health and welfare fields. The



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4 Association would like to go on record as supporting the
5 brief of our national Association and to further emphasize
6 its contention that it is impossible to separate the
7 welfare and education of the retarded from health needs.

8 Most of the mentally retarded can benefit
9 from locationally orientated education programmes. In
10 brief there are three major categories of mental re-
11 tardation, educable retarded, which constitutes in this
12 Province about 18,000 people. This group is capable of
13 some degree of achievement in traditional academic sub-
14 jects such as reading and writing and with training will
15 be able to maintain itself reasonably independent of the
16 community.

17 Next is the trainable retarded child who
18 constitute about 4800 in this Province who are capable
19 of benefit from training and self-care, social and simple
20 job and vocational skills. A good many of these, con-
21 trary to public opinion, are capable of earning a living.

22 Then there is the severely retarded and these
23 constitute about 1200. These people need intensive in-
24 dividual care to enable them to develop their capabilities
25 in minimal self-care. They have no vocational potentials
26 whatsoever.

27 The existing facilities in Saskatchewan are
28 shown in Appendix A and I will not go over them for you
29 due to the necessity of cutting this brief short. I
30 should point out that apart from the two institutions
and the special education which is woefully lacking but
nevertheless, there are no concrete social services for
this outside of the institutions and in the institutions

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some degree of achievement in reading and academic sub-
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and the special education which is usefully lacking but
nevertheless, there are no concrete social services for
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4 very little is able to be accomplished due to the short-
5 age of space and staff. The following recommendations
6 are made by the Association.

7 1. The deveopment of a mental retardation
8 clinic. The Saskatchewan Association recognizes the
9 family doctor as the key person in identifying and treat-
10 ing, particularly the severely and moderately retarded
11 children. It is not only imperative that he be well in-
12 formed and alert to the developmental anomalies but in
13 addition have ready access to specialized clinics when
14 retarded mental development is suspected. By way of
15 example, the value of a need for early detection should
16 be noted in relation to such metabolic disorders as
17 phenylketonuria and galactosemia which are listed in
18 Appendix B.

19 The need is therefore apparent for the develop-
20 ment of diagnostic, evaluation and consultation clinics
21 particularly orientated to the problems presented in the
22 care, treatment and handling of the retarded. These
23 clinics should be centrally located, should be staffed
24 by a team of specialists. It is recommended the clinic
25 in addition to providing physical, emotional and intel-
26 lectual evaluation, parent counselling and referral
27 services, would aid as a focal point for ongoing research
28 and further opportunities for professional personnel
29 training.

30 2. Home care and parent education. No single
resource provides care and training to mentally retarded
children has received as little attention as the home.
Most of Saskatchewan's estimated 24,000 perhaps greater



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care, treatment and habilitation of the retarded. These

clinics should be centrally located, should be staffed

by a team of specialists. It is recommended the clinic

in addition to providing physical, emotional and intel-

lectual evaluation, parent counselling and referral

services, would also be a focal point for ongoing research.

2. Home care and parent education. No single

resource provides care and training to mentally retarded

children has received as little attention as the home.

Most of Saskatchewan's estimated 24,000 perhaps greater



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4 than 90 percent live at home and under parent guidance
5 and supervision. The integration into a family of a
6 mentally retarded member possessed of characteristics
7 so at odds with our socio-cultural values is not an easy
8 task. Parents must have help to achieve such difficult
9 yet necessary ideals of conduct. It must be noted that
10 it is certainly much cheaper to provide parents with
11 generous financial and practical assistance than to pro-
12 vide hospital care. Further, much more important and a
13 point not fully appreciated, that optimum emotional
14 development cannot be achieved through institutional
15 placement. No institution can replace a home. The
16 parent areas of need are:

17 a) Opportunity for intensive counselling
18 and thorough case work with each family. This
19 could be facilitated by addition of specially
20 trained personnel to mental health, health region
21 and mobile clinics.

22 b) There is also the need for field workers
23 trained in special techniques, to work in consul-
24 tation with the family, doctor, clinics, etc.,
25 to go into the home to offer the parent special
26 instruction in the handling, feeding and special
27 care of the child.

28 Next we would remind the Commission that
29 there is a two-year period between the family allowance
30 cut-off at the age of 16 years and the provision of the
disabled person's allowance at 18 years. There is need
to supplement the family allowance received by parents
of handicapped children and to extend the eligibility



than 50 percent live at home and under parent guidance and supervision. The information that a family of mentally retarded member possessed of characteristics so at odds with our social cultural values is not an easy task. Parents must have help to achieve such difficult yet necessary goals of treatment. It must be noted that it is certainly more pleasant to provide parents with generous financial and practical assistance than to provide helpful advice. However, much more important and a point for which we must strive, that optimum emotional development can be achieved through understanding and placement. No individual can achieve a goal if the parent is not of the same mind.

It is necessary for individual counseling and therapy to work with each family. This could be done in a group and also individually. Parents need to be trained in mental health, health care and in general.

It is also necessary for the field worker to be trained in social recognition, to work in cooperation with the family, doctor, educator, etc., to provide the same to other the parent needs. Instruction in the handling, feeding and special

Next we would have a discussion that there is a two-year period between the family of owners out-off at the age of 16 years and the provision of the disabled person's allowance at 18 years. There is need to supplement the family allowance received by parents of handicapped children and to extend the eligibility



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4 age to 18 or, possibly, to make the disabled person's
5 allowance payable at 16 years of age. This assistance
6 would greatly help in the purchase of special medication
7 and the added costs of special diet where applicable.

8 Where clinic treatment is prescribed for an
9 individual consideration should be given to the trans-
10 portation of the individual to and from the treatment
11 centre in specific cases where need is established.
12 Economic hardship should not preclude any individual
13 from receiving rehabilitative services.

14 Day care centres, a resource to provide
15 physical care and supervision of handicapped children
16 on a non-continuous basis during the day time only is
17 a necessity. This facility would afford opportunity for
18 kindergarten-like education and socialization experience
19 and would have value in orientating families as to the
20 nature of their child's developmental difficulties.
21 This would provide much needed baby-sitting service, to
22 afford parents some relief from constant care and would
23 induce the need for institutionalization of many children.

24 I would like next to deal with the section
25 on rehabilitation since this is a very real need.
26 Vocational training and sheltered workshop opportunities
27 for the mentally retarded are totally inadequate or non-
28 existent in areas. The retarded adult presents special
29 need in terms of employment, social adjustment, recreat-
30 ion and daily living, and again none of these are
adequately met.

The Federal Government Bill C84 concerning
the vocational rehabilitation of disable persons does



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4 not offer sufficient benefit to the mentally retarded
5 because of their lack of vocational potential. It is
6 recommended that this bill be amended so that the cost
7 of instructors, teachers and social workers may be shared
8 between Federal and Provincial Governments.

9 For the efficient functioning of sheltered
10 workshops, Government support is necessary and it is
11 recommended that the rehabilitation department of the
12 Federal Government's Ministry of Labour pay urgent at-
13 tention to the adequate provision of such workshops.

14 Since there is a need for more knowledge
15 about the desirable programmes for sheltered workshops
16 it is recommended that money be available from Government
17 sources for research on this problem.

18 On labour, the Association recommends the
19 addition of a specially trained person to the Special
20 Placements Division of the National Employment Service
21 to deal with selective placement of mentally retarded.
22 We further recommend the revision of existing labour
23 regulations to permit employment of mentally deficient
24 persons at less than Union Wages while at the same time
25 providing a safeguard against exploitation.

26 With regard to armed service postings, con-
27 sideration should be given to armed service personnel
28 in terms of compassionate postings and special needs
29 as relating to mentally retarded members of these
30 families.

Low rental housing -- we recommend the ex-
tension of low rental housing as to include construction
of hostels, short stay homes for mentally handicapped.



National Health and Welfare; as indicated earlier there is a need for greater orientation of those persons first encountering the mentally retarded, particularly for the physicians. This could be accomplished by the inclusion in schools of medicine of curriculum items on retardation and the special orientation of a senior nurse and/or a medical health officer in each health unit on the problem of retardation.

This Association recommends the establishment of a drug bank where medications needed for the special care of chronically handicapped persons with continuing need could be obtained at wholesale price. We are not recommending a Government give-away programme but such a drug bank could be partially subsidized. The essential feature is the voluntary agencies and parents could contribute towards the cost of expenses and of drugs. I might point out that the cost of maintaining a child in phenylalanine is over \$1,000, a year.

THE CHAIRMAN: For how many years?

DR. BUCKWOLD: It is not well established but it is at least seven or eight years.

Grants in aid to universities in Canada should be provided for adequate instruction in the various pertinent faculties on retardation problems, that is, medicine, education and social work.

Grants in aid to provide assistance for medical practitioners, teachers, social workers and other medical and para-medical staff to receive special training are also indicated.

As far as institutions are concerned, in the



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4 institution programme in Saskatchewan the following
5 needs are apparent:

6 a) Additional budget to allow for increase
7 in staff particularly in areas of teacher, occupation-
8 al and recreational staff.

9 b) Quite a number of patients may be em-
10 ployed in labour groups on day programmes through
11 controlled homes or half-way houses to make adults
12 partially self-supporting given the correct en-
13 vironment.

14 c) There is a waiting list of approximately
15 300 patients in the community many of whom have
16 multiple disabilities and are acute nursing
17 problems. Extra facilities are needed for their
18 special care.

19 d) In terms of future expansion this
20 Association is in favour of decentralized units,
21 small cottage or hostel types strategically lo-
22 cated to provide service as near to home as
23 possible much in the same line as the regional
24 community hostel plan in Saskatchewan, providing
25 these units through N.H.A. legislation could be
26 handled similar to the Dominion Provincial Health
27 Grants.

28 There is no co-ordinated programme of re-
29 search in the causation, treatment and prevention of
30 mental retardation. It should be emphasized that re-
search should embrace not only the physical condition
but also the psycho-socio-vocational needs of the
retarded person.



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a) Additional staff to allow for increase

in staff per cent in terms of teachers, occupation-

al and professional staff.

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given in future years on the programme of

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c) There is a waiting list of a number of

100 patients in the community who are in

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association is in terms of occupational and

small groups or for the integration of

need to provide services at home and

possible work in the same line as the regional

community mental plan is to be developed, providing

these units through the local health

mental health to the local health

There is no need for a further increase of re-

search in the education, treatment and prevention of

mental retardation. It would be suggested that re-

search should extend not only the physical condition

but also the social-vocational needs of the



The Association recommends that the services of the National Research Council of Canada, medical research division be extended to include fields of socio-vocational problems and that particular attention be given to grants for study in the areas of retardation.

Community acceptance: a basic factor in the recognition of all areas of mental deficiency is a lack of community acceptance of both the retarded individual and his special problems.

In conclusion we submit that attention to the unmet needs of the retarded could add a great deal towards increasing their usefulness to themselves and to the community. The Association in recommending these things realizes that it cannot be achieved all at once but it is recommended that the services for the Federal Government to implement could possibly follow these steps:

a) To participate in construction with grants for the building of hostels and other community services.

b) To provide more training grants for the development of staff especially in the socio-vocational fields.

c) To make available more grants for basic research.

This Association sees the need for a re-assessment of the role of voluntary effort in the development of services for the retarded.

THE CHAIRMAN: Thank you very much, Dr. Buckwold. Dr. Roeher, have you anything you want to add at this time?



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THE CHAIRMAN: Thank you very much, Dr. Buckwald. Dr. Goehar, have you anything you want to add at this time?



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4 DR. ROEHER: Just a comment that as Govern-
5 ment support goes, both Provincially and Federally, for
6 the retarded it tends to help either those who are, on
7 the one hand, so severely retarded and helpless that
8 they need institutionalization and there is some help
9 for those and it helps those who are reasonably capable
10 of achieving economic and vocational independence. There-
11 for, such programmes as the schedule R, Canadian Training
12 Programme and through the C84 legislation that is coming
13 up. The real problem, as society now believes, is that
14 most of these people can live in society. The real prob-
15 lem is the in-between group who have no help, they are
16 still dependent on the family and because they cannot
17 meet this minimum standard, no services are available to
18 them. This is really the gap that is critical. I think
19 we have to decide eventually where we leave this problem.
20 It probably will come to the point where there will be
21 increasing public pressure for more institutionalization
22 or do something to help the parent at an early stage where
23 he or she can cope with the problem for a longer period
24 before institutionalization is required, keep the child
25 in the community. This has been demonstrated that it can
26 be done in some selected small areas, mostly in the United
27 States and we have not grappled with this problem here
28 as yet.

29 THE CHAIRMAN: Mr. Dolan?

30 MR. DOLAN: Just to reinforce what Dr. Buckwold
brought out and Dr. Roeher that we have perhaps overlooked
the member of the rehabilitation team, the family, and
this is a member of this team that does need support.



DR. ROEBER: Just a comment that as Government support goes, both provincially and Federally, for the retarded it tends to help either those who are, on the one hand, so severely retarded and helpless that they need institutionalization and there is some help for these and it helps those who are reasonably capable of solving economic and vocational independence. There for, such programs as the schedule B, Canadian Training Program and through the C.I. Institute that is coming up, the real problem, as society now believes, is that most of these people can live in society. The real problem is the in-between group who have no help, they are still dependent on the family and because they cannot meet this minimum standard, no services are available to them. This is really the gap that is critical. I think we have to decide eventually where we leave this problem. It probably will come to the point where there will be increasing public pressure for more institutionalization or do something to help the parent in an early stage where he or she can cope with the problem for a longer period before institutionalization is required, keep the child in the community. This has been demonstrated that it can be done in some selected small areas, mostly in the United States and we have not grappled with this problem here.

THE CHAIRMAN: Mr. Dolan?

MR. DOLAN: Just to reinforce what Dr. Buckwalter brought out and Dr. Roebert that we have perhaps overlooked the member of the rehabilitation team, the family, and this is a member of this team that does need support.



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4 Certainly it has no educational training and it is a
5 person that we are focusing a lot of attention on in our
6 Association.

7 THE CHAIRMAN: Dr. Buckwold, just in intro-
8 ducing yourself, you are the head of the Department of
9 Pediatrics at St. Paul's Hospital in Saskatoon?

10 DR. BUCKWOLD: Yes, sir.

11 COMMISSIONER GIRARD: I would like to ask
12 Mr. Dolan, you just mentioned there was a great need
13 for parent education in the field of the retarded
14 children. Are there any organizations whose primary
15 function is to do this kind of education?

16 MR. DOLAN: It is one of our primary functions
17 which we have not sort of got around to carrying out as
18 we should be. We have been extremely involved in day
19 schools and other areas but there is a trend to recog-
20 nize this as a very real problem and it is time to do
21 something about it. In this area we have sponsored a
22 parent seminar and we do have parent group meetings,
23 which serves a part of this need but this requires in-
24 tensive well instructed programmes directed at the family
25 and the parents.

26 COMMISSIONER GIRARD: Do you have profes-
27 sional workers doing this sort of work?

28 MR. DOLAN: As a voluntary agency, no. We
29 do have co-operation from the Department of Public Health
30 and this seminar was conducted at the training school
at Moose Jaw. From this point of view we have the ad-
vantage of professional leadership within our organization
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4 COMMISSIONER GIRARD: Dr. Buckwold, I would
like to know, you state in the Appendix A, on page 15:

5 "In 13 public health regions, nurses at-
6 tempt to provide service through well-baby clinics."
7 What types of service do the nurses render?

8 DR. BUCKWOLD: This is primarily a service
9 for well babies, and incidentally if children are picked
10 up who are not developing normally, if the nurse is able
11 to spot it, she does try to the best of her ability to
12 refer them on, usually back to their own family physician.
13 In many areas, in some areas this function is better than
14 others. In the urban areas it functions very poorly. In
15 the rural areas, where there is more reliance on the well-
16 baby clinics, the nurses do provide a certain service,
17 but it is only an incidental service. They really don't
18 have the special training, nor do they have the time to
19 follow up in many instances, although quite seriously,
20 many of them do a very wonderful job against terrific
odds.

21 COMMISSIONER GIRARD: Is the test for
phenylketonuria done routinely in all well-baby clinics?

22 DR. BUCKWOLD: No, I think an attempt is
23 being made to do this. You realize, of course, that one
24 negative test does not mean a negative baby, and they
25 have to be done at 3 to 4 weeks of age, in order to get
26 a reasonable test. In some areas they are attempting to
27 do this, and I think the general practitioners' organi-
28 zation is making a concentrated effort to do this in the
29 doctor's office. To my knowledge it is not done on an
30 organized basis.

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4 COMMISSIONER McCUTCHEON: I was going to say,
5 Doctor, that since I left Toronto I read that the public
6 health nurses in the Department of Public Health will be
7 making this test routinely, but I thought it was about
8 four weeks.

9 DR. BUCKWOLD: There is a little bit of dif-
10 ficulty in this. I must point out, being a pediatrician,
11 it is that you cannot always have a wet diaper, and you
12 cannot always get the child to void at the proper time.

13 COMMISSIONER GIRARD: The mother, I presume,
14 could be trained to help in this?

15 DR. BUCKWOLD: Yes.

16 COMMISSIONER GIRARD: It is not a costly
17 test, is it?

18 DR. BUCKWOLD: No, the test costs about 10
19 cents apiece. When you consider that you get about one
20 case in 20,000, this could be an appreciable amount.
21 Mind you, it would not cost any more than feeding the
22 children milk for a year. The other tests, the diaper
23 tests are most inexpensive, less than a fraction of a cent.

24 COMMISSIONER GIRARD: I also note that you
25 mention on page 10 that: "-- there is a need for more
26 knowledge about the desirable programmes for sheltered
27 workshops. It is recommended that money be available
28 from Government sources for Research on this problem."
29 Has any research been done on the problem of the programme
30 for sheltered workshops, that you know of?

DR. BUCKWOLD: Yes, there are several work-
shops that have been done in the States on an individual
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5 one of the problems is that we cannot take a situation
6 in New York City and transplant it to Regina or Saskatoon,
7 since our economies are totally different. However, both
8 in England and in the United States, a great deal has
9 been done, indicating that the people with I.Q.'s, if we
10 can use this criterion, can be made self-sufficient in
11 many instances, people with I.Q.'s of less than 50.

12 COMMISSIONER GIRARD: Is the I.Q. the only
13 test that you use for selection of a child for a workshop?

14 DR. BUCKWOLD: No, the I.Q. is not the only
15 test. There is no only test. The only test is the test
16 of functioning, and the ability of a child to socialize,
17 and to develop. As you know, there has been a great deal
18 of work done on differential diagnosis in the intelligence
19 test that we are trying to set up here in one of our areas,
20 but it has not yet been established.

21 THE CHAIRMAN: Where do you get the funds
22 for the operation of your organization, the Association
23 for Retarded Children?

24 MR. DOLAN: We are a member of United Appeals
25 in several areas, and we have conducted a limited
26 Provincial fund drive. We are just getting around to
27 getting better organized in the fund areas. We have been
28 so busy in trying to institute programmes and latching on
29 to existing programmes.

30 THE CHAIRMAN: You made mention of the day
schools, Mr. Dolan. Would you tell us about this, and I
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THE CHAIRMAN: You make mention of the day schools, Mr. Bolan. Would you tell us about this, and I see that perhaps in your modesty you didn't refer to them



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4 by name, to the organization of the John Dolan School in
5 Saskatoon, and the work that it is doing.

6 MR. DOLAN: The day school movement, what
7 is referred to as the day school movement, actually refers
8 to a group of retarded that are categorically referred to
9 here as trainable, or with I.Q. levels of 25 to 50, ap-
10 proximately. These children were traditionally excluded
11 from the regular school programmes. In the last number
12 of years there has been very ready acceptance, let us say,
13 on the part of school authorities and the Department, to
14 pick up the tab for this group, and now in Saskatchewan
15 the situation exists that schools for trainable are by
16 and large the responsibility of regular school authorities.
17 This is a very brief summary.

18 THE CHAIRMAN: And there is such a school
19 in Saskatoon?

20 MR. DOLAN: Actually there are 280 children
21 in classes throughout Saskatchewan now. There are schools
22 in all the larger major centres, and approximately eight
23 of the small areas.

24 THE CHAIRMAN: How does the rural child, who
25 does not live in one of these areas, how is he incorporated
26 into that day school programme?

27 MR. DOLAN: In the larger centres he is
28 boarding at a foster home, or a similar setting, and in
29 the rural area he is generally a child in the school bus,
30 and comes in with other children. There is a classroom
and there are six or eight children, and he comes along
with all the rest of the kids.

THE CHAIRMAN: What has been the experience,

by name, to the organization of the John Dolar School in Saskatoon, and the work that it is doing.

MR. DOLAN: The day school movement, that

is referred to as the day school movement, actually refers to a group of retarded that are categorically referred to here as trainable, or with I.Q. levels of 25 to 50, approximately. These children were traditionally excluded from the regular school programmes. In the last number of years, there has been very ready acceptance, let us say, on the part of school authorities and the Department, to pick up the end of this group, and now in Saskatchewan the situation exists that schools for trainable are by and large the responsibility of regular school authorities. This is a very brief summary.

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THE CHAIRMAN: What has been the experience,



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3 I mean the result in training?

4 MR. DOLAN: Well, I think we certainly have
5 discovered that these children have abilities, and these
6 abilities have been developed to a level where there has
7 been created a rather urgent situation to move into some-
8 thing else. It is interesting, I think, that we have
9 quite a number of older children in our day schools now
10 who are looking for something that is a little more mature,
11 that is a little more in keeping with their chronological
12 age, and this is creating considerable urgency on the
13 part of the Association to become involved in the next
14 area.

15 THE CHAIRMAN: Is there anything in this
16 idea, I have heard that if a child, it might be a potential-
17 ly retarded child, is left without any curative train-
18 ing programme, that there will be deterioration, and on
19 the other hand that his position may be, his category
20 may be increased, or improved, by a proper programme?

21 MR. DOLAN: I wouldn't know that his category
22 would change, but it certainly would be a very unhappy
23 child, and as such he would certainly regress, and I
24 certainly think that some of our children who do have to
25 go back home to no programme are almost as unhappy as
26 they were before they began training, because they have
27 experienced a certain amount of satisfaction and pride,
28 and have achieved a certain level, and to go home to
29 nothing is certainly a situation of regress.

30 DR. BUCKWOLD: Mr. Dolan was saying there
may not be any increase in I.Q. as such, but certainly
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8 would not be able to function.

9 So training takes a tremendous role. I
10 might also say, to expand what Mr. Dolan said, the problem
11 that we are confronted with now in the day school system
12 is that these older children are getting to the point
13 where they no longer belong in the day school. The
14 Council for Crippled Children and Adults have a vocation-
15 al programme which is wonderful. We can assess these
16 children and say, well this child may be able to do some-
17 thing. The only difficulty is that having done the as-
18 sessment we have no workshop and no place for them to go,
19 so much of the work done in the training programme will
20 be negated, unless we can go to the next step.

21 THE CHAIRMAN: And you have recommendations
22 for that next step in your submission here today?

23 DR. BUCKWOLD: Yes, sir.

24 COMMISSIONER STRACHAN: What is the maximum
25 chronological age for a child to attend such a school, or
26 is there one?

27 MR. DOLAN: There is not a hard and fast
28 rule. There has not been a hard and fast rule established
29 in Saskatchewan. In Ontario I believe they have a cut-
30 off line of 18. In Saskatchewan we have children in
classes until 21. I think the Department is going along
with this in lieu of, there is no other place for the



what we are after. A child learns not only this way, but this way, and if we can continue his teaching programme so that he learns more in socialization and in techniques, if he is down low in the scale, he can still function at that level, and without that training he would not be able to function.

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4 child at this time.

5 THE CHAIRMAN: It is the elementary school
6 system that co-operates, you do not carry it into the
7 high school system?

8 MR. DOLAN: That is correct.

9 COMMISSIONER STRACHAN: What Government
10 assistance do you get?

11 MR. DOLAN: The School Board, by and large,
12 at the same cost as it would cost to educate a normal
13 child, and the Department of Education picks up the tab
14 for the balance, which comes out at about \$500. per
15 child.

16 THE CHAIRMAN: In the matter of teachers in
17 these schools, what problems are you encountering there,
18 and is there any help forthcoming in that regard?

19 MR. DOLAN: There certainly is need for more
20 specialized training at the teacher level. There is no
21 question. We are having some difficulty in getting
22 teachers who have sufficient depth of training to really
23 cope with the multiplicity of problems these children
24 present.

25 COMMISSIONER STRACHAN: Where these children
26 are incorporated into the day school, public school, do
27 the teachers receive a salary commensurate with the other
28 teachers?

29 MR. DOLAN: They are on the same staff, there
30 is no difference at all.

COMMISSIONER STRACHAN: Have you any schools
set apart for retarded, or sponsored, or built by ser-
vice clubs, or anything of that nature?

child at this time.

THE CHAIRMAN: It is the elementary school system that co-operates, you do not carry it into the

MR. DOLAN: That is correct.

COMMISSIONER STACHAN: What Government

assistance do you get?

MR. DOLAN: The School Board, by and large,

at the same cost as it would cost to educate a normal child, and the Department of Education picks up the tab for the balance, which comes out at about \$500. per child.

THE CHAIRMAN: In the matter of teachers in these schools, what problems are you encountering there, and is there any help forthcoming in that regard?

specialized training at the teacher level. There is no question. We are having some difficulty in getting teachers who have sufficient depth of training to really cope with the multiplicity of problems these children

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arate clubs, or anything of that nature?



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4 MR. DOLAN: Well, most of our construction
5 up to the present time has been constructed on a voluntary
6 basis, with the service groups contributing sometimes
7 half, sometimes more. And the Government coming along
8 with a matching grant. This is the way the larger
9 schools have been built so far, apart from Regina.

10 COMMISSIONER STRACHAN: But Government seems
11 willing to contribute a 50 --

12 MR. DOLAN: It is not quite in that ratio,
13 but it is substantial.

14 THE CHAIRMAN: And there is no question the
15 Department of Education has given full co-operation?

16 MR. DOLAN: Every recognition and full co-
17 operation.

18 COMMISSIONER STRACHAN: Have you any trouble
19 with local school boards on that?

20 MR. DOLAN: There is a small problem, shall
21 we say of orientation, on the part of boards. There is
22 perhaps a little reluctance to become involved with this
23 along with all the other school problems. This is a
24 matter that is clearing itself as we go along.

25 COMMISSIONER STRACHAN: Do you find any feel-
26 ings of parents of normal children regarding these
27 children being in attendance at the school?

28 MR. DOLAN: I haven't heard of any negative
29 reactions. It has been very satisfactory, and we have
30 had many instances on the positive side where the other
children have played with these children in the play-
ground and taken them home to parties, and things of
this nature.



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this nature.



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COMMISSIONER STRACHAN: Isn't this the first step towards educating the public? The children will grow up sympathetic to these children, or individuals?

MR. DOLAN: It helps tremendously.

DR. BUCKWOLD: I should point out, sir, that there are no schools in Saskatchewan in which the trainable retardee is in the ordinary school building with the other children. This is the educable retarded that Mr. Dolan has referred to in the regular school system, in the ordinary public school building.

COMMISSIONER McCUTCHEON: But it is in a separate class?

DR. BUCKWOLD: Yes, auxiliary classes.

THE CHAIRMAN: But this other group we were talking about, like the John Dolan School, or the Harrow de Groot School here in Regina, is not on the same site as the elementary school?

MR. DOLAN: No, they are in separate premises. I don't like to correct Dr. Buckwold, but there are several instances where the trainable class is fairly close, it is in the school building, and the same grounds.

COMMISSIONER STRACHAN: I haven't yet got the differentiation there, and I know you do not like, or prefer the term I.Q., but do I understand that none with an I.Q. beyond 50 would be in the educable class?

MR. DOLAN: That is correct.

COMMISSIONER STRACHAN: They would be in separate schools?

DR. BUCKWOLD: Or, as Mr. Dolan pointed out,

grow up sympathetic to these children, or individuals

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COMMISSIONER McCUTCHEN: But it is in a

separate class?

DR. BLACKWOLD: Yes, six many classes.

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COMMISSIONER STRACHAN: It would be in



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3 I guess in some rural areas.

4 THE CHAIRMAN: Now, about this interesting
5 suggestion of a revision of existing labour regulations
6 to permit employment. Have you tried to carry that for-
7 ward at all at any governmental level?

8 DR. ROEHER: No, we haven't been too success-
9 ful. As a matter of fact we have run into much dif-
10 ficulty in trying to make exceptions, and they have run
11 into the problem of their union or association objecting
12 to this because it interferes with stepping up. We are
13 not suggesting that any steps be taken which would inter-
14 fere with the normal labour processes, but it is a little
15 illogical for us to spend vast sums of money and have a
16 social problem by which we rehabilitate to a point, and
17 then cannot make exceptions. In most instances where
18 we work with individual employers, and we have made in-
19 dividual placement, this has been worked out, and in
20 Saskatchewan there is provision on a special permit
21 basis to do this, but it is a very awkward thing, and
22 we are not quite sure just what the answer is, but there
23 is need to look at this very seriously, because it is
24 not just a case of mentally retarded, it is a case of
25 a whole host of people of various conditions, whether a
26 stroke, or whatever it is, people are deprived at a
27 certain point in life because of rigidity within this
28 area. So we are not quite sure what the answer is, but
29 we do suggest it needs very serious study.

30 THE CHAIRMAN: To find some procedure by
which a person may be employed at a wage comensurate
with his productivity?

I guess in some rural areas.

suggestion of a revision of existing labour regulations to permit employment. Have you tried to carry that forward at all at any governmental level?

DR. ROSENBERG: No, we haven't been too successful.

As a matter of fact we have run into much difficulty in trying to make exceptions, and they have run into the problem of their union or association objecting to this because it interferes with sleeping up. We are not suggesting that any steps be taken which would interfere with the normal labour processes, but it is a little illogical for us to want vast sums of money and have a social program by which we subsidize to a point, and then cannot make exceptions. In most instances where we work with individual employers, and we have made individual arrangements, this has been worked out, and in Saskatchewan there is provision on a special permit basis to do this, but it is a very awkward thing, and we are not quite sure just what the answer is, but there is need to look at this very seriously, because it is not just a case of mentally retarded, it is a case of a whole host of people of various conditions, whether a stroke, or whatever it is, people are deprived at a certain point in life because of disability within this area. So we are not quite sure what the answer is, but we do suggest it needs very serious study.

THE CHAIRMAN: To find some procedure by

which a person may be employed at a wage commensurate with his productivity?



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3 DR. ROEHER: Right.

4 COMMISSIONER McCUTCHEON: That is a very
5 dangerous theory.

6 THE CHAIRMAN: On this matter of the hiatus
7 between the ages of 16 and 18, have representations been
8 made in that category?

9 MR. DOLAN: I believe a brief was presented
10 to National Health and Welfare from our national body in
11 this respect.

12 THE CHAIRMAN: But that void exists?

13 MR. DOLAN: That void has not been closed
14 yet.

15 COMMISSIONER McCUTCHEON: Your national body,
16 I take it, will be making a submission?

17 MR. DOLAN: This is correct.

18 COMMISSIONER BALTZAN: Dr. Buckwold, you
19 mention here that you have now 24,000 mentally retarded:
20 you attribute this number to an increased life span?

21 DR. BUCKWOLD: No, sir; this is based largely
22 on estimates that are pretty well uniform throughout
23 various countries of the incidence of mental retardation
24 being about 3 percent of the population.

25 COMMISSIONER BALTZAN: Have you offhand any
26 comparative figures with statistics of, say, 10 or 20
27 years ago?

28 DR. BUCKWOLD: No.

29 COMMISSIONER BALTZAN: Is the incidence in
30 new births increasing? Have you any record of that?

DR. BUCKWOLD: There are statistics in-
dicating that there is an increase in congenital

COMMISSIONER ROBERTSON: That is a very

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3 abnormalities due possibly to better obstetrics and pro-
4 longing gestation that would otherwise have been dis-
5 turbed, and also keeping alive smaller prematures, and
6 decreasing the premature rate a little bit and increasing
7 the gestation period, and increasing the recovery rate --
8 at least, the medical recovery rate -- from many chronic
9 illnesses. There is this increase in the new-born period.
10 So, we have more people limping who would previously have
11 died.

12 COMMISSIONER McCUTCHEON: And more cases
13 identified too?

14 DR. BUCKWOLD: And there is the identification,
15 yes.

16 COMMISSIONER BALTZAN: Are there any proofs
17 that prenatal attention is proving preventive in this
18 problem?

19 DR. BUCKWOLD: Oh yes, the erythroblastotic,
20 the RH baby; the early detection of the erythroblastotic
21 RH infant, and the implementation of proper treatment
22 can eliminate this disease in the new-born, or almost
23 eliminate it in the new-born except in certain instances.
24 The role of maternal rubella, or German Measles in the
25 first three months of pregnancy, and then the increase
26 in the ability to prolong pregnancy so that the child is
27 less premature. There are figures to substantiate this,
28 and I can get them for you.

29 COMMISSIONER BALTZAN: I appreciate your
30 answers very much. Will you help my medical knowledge
just one bit more: regarding the early detection of
certain types, you have mentioned metabolic disorders:



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COMMISSIONER BALTIMAN: Are there any people
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certain types, you have mentioned metabolic disorders;



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3 can they be maintained -- you said at least eight years:
4 can their recovery continue? Is there an expectancy of
5 curability?

6 DR. BUCKWOLD: Yes, according to the in-
7 vestigations that have been carried out -- according to
8 the literature used. My own personal experiences with
9 these children in my own practice has been a little dis-
10 appointing, mainly because I am treating the youngest
11 -- and that is a child of six or seven months: theo-
12 retically I should be able to improve this child con-
13 siderably. The others -- I have had five or six of
14 them -- and they are really relatively rare. They come
15 in at periods of 13 or 14 months, and all of them --
16 the ones I have seen have all been under medical super-
17 vision, I am sorry to say, or baby clinic supervision,
18 and the diagnosis has been corrected. It is easy for
19 me to be smart, because I am seeing it much later.

20 COMMISSIONER BALTZAN: You can expect a
21 payoff in salvage?

22 DR. BUCKWOLD: Yes. Theoretically, if we
23 can get them early enough and maintain them on a special
24 diet, yes.

25 COMMISSIONER BALTZAN: Thank you.

26 THE CHAIRMAN: Thank you very much Dr.
27 Buckwold, Dr. Roeher and Mr. Dolan. We are grateful to
28 you. We know that we have kept you longer than you had
29 expected to be, and we appreciate the fact that you
30 stayed without complaint and have been of such assistance
to us.

DR. BUCKWOLD: Thank you very much, Mr.

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WILL BALLMAN: Thank you very much, Dr.

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you. We know that we have kept you longer than you had
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DR. BUCKWOLD: Thank you very much, Mr.



Chairman. I would like to thank you and your Commission for listening to us. We enjoyed the wait because it gave us a few pointers on how to answer the questions.

I would like to make one point, and that is that some of the points brought out in this brief may not appear to have much bearing on medical care: the education and social and vocational development programmes that we have recommended. We submit, however, this is extremely important because it is complementary to a health care programme, and without it the health care is really not worthwhile.

THE CHAIRMAN: Ladies and gentlemen, we are going to sit to-night in another room in this building, starting at seven-thirty, when the submissions from the Victorian Order of Nurses, Saskatchewan Division, the Saskatchewan Registered Nurses' Association, and the Saskatchewan Farmers' Union will be received. We will adjourn now until seven-thirty.

---RECESS UNTIL 7:30 P.M.

---ON RESUMING AT 7:30 P.M.

SUBMISSION OF THE VICTORIAN ORDER OF NURSES,

SASKATCHEWAN DIVISION

APPEARANCES:

MR. D.E. MALDEN - President

MISS C. SWINTON - Regional Director of the
Victorian Order of Nurses
for Saskatchewan

MRS. H.G. HARROWER - Moose Jaw

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SUBMISSIONS TO THE VICTORIAN ORDER OF NURSES

ATTENDANCE:

MISS C. SWINTON - Regional Director of the Victorian Order of Nurses for Saskatchewan

MRS. H.G. HARKOWER - Moose Jaw



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3 APPEARANCES: continued

4 MRS. P. ROSS - Saskatoon.
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6 ---EXHIBIT NO. 83: Submission of the Victorian Order
7 of Nurses, Saskatchewan Division

8 MR. MALDEN: Mr. Chairman and Commissioners,
9 at the time the Victorian Order of Nurses was founded
10 in 1897 there was a great need in Western Canada for a
11 district nursing service for the early settlers in
12 sparsely settled areas. The establishment of six cot-
13 tage hospitals and ten country nursing districts as-
14 sisted in meeting this need. When the provincial govern-
15 ment assumed responsibility for health services the
16 Victorian Order withdrew from these activities. This
17 flexibility in providing a service to meet the existing
18 needs of the people has always been, and still is, an
19 inherent factor in Victorian Order policy.

20 At present four branches in Saskatchewan
21 provide visiting nursing service to 28% of the popu-
22 lation of the province. The organization of branches
23 in Saskatchewan has not been dramatic but service has
24 been inaugurated wherever there has been an expressed
25 need and where community support was given. In its
26 submission to the Advisory Planning Committee on
27 Medical Care, Department of Public Health, Province of
28 Saskatchewan in January 1961, the Victorian Order stated
29 it would be willing to plan in co-operation with other
30 health agencies for further development of existing
services, organization in new areas, and demonstration
of new services.

MR. F. ROSS - Saskatoon.

---EXHIBIT NO. 83: Submission of the Victorian Order of Nurses, Saskatchewan Division

at the time the Victorian Order of Nurses was founded in 1881 there was a great need in western Canada for a district nursing service for the early settlers in sparsely settled areas. The establishment of six cottage hospitals and ten country nursing districts assisted in meeting this need. When the provincial government assumed responsibility for health services the Victorian Order withdrew from these activities. This flexibility in providing a service to meet the existing needs of the time has always been, and still is, an inherent factor in Victorian Order policy.

At present four branches in Saskatchewan provide visiting nursing service to 26 of the population of the province. The organization of branches in Saskatchewan has not been dramatic but service has been maintained wherever there has been an expressed need and where community support was given. In its submission to the Advisory Planning Committee on Medical Care, Department of Public Health, Province of Saskatchewan in January 1961, the Victorian Order stated it would be willing to plan in co-operation with other health agencies for further development of existing services, organization in new areas, and demonstration of new services.



The major part of the service in the four branches in Saskatchewan is for persons sick at home with medical and surgical conditions. From statistical data on patients dismissed from service in 1960, three quarters of the visits were to patients suffering from long term illnesses. In a brief submitted in March 1961 by the Victorian Order of Nurses to the Aged and Long Term Illness Survey Committee, Government of Saskatchewan, recommendations were made regarding the improvement of the quality of care to patients with conditions of chronic illness. The Victorian Order has been an active participant in the Home Care Rehabilitation Project conducted under the direction of the Department of Rehabilitation Medicine at the University Hospital. Although this Home Care Program is rather limited, there is interest in establishing other home care programs in the province and the Victorian Order has been asked to assist in the planning for two of them. Where home care programs are not being conducted, hospital referral programs would ensure patients who require it, continuing care at home when they leave hospital.

Part-time health counselling might be extended and made available to employees in industries which are not large enough to employ a full-time nurse.

At the present time over half the nurses have public health preparation beyond the basic course. There is a need for well qualified, experienced nurses with leadership ability to assist in the development of any new programs.



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4 Since 1945 the provincial government has paid
5 each branch on a fee-per-visit basis for service to
6 certain of its wards and certain cancer patients. In
7 1960, 27% of the total income in the four branches came
8 from this source. In 1961 legislation was passed in re-
9 lation to a program of medical care for all people in
10 Saskatchewan. The Victorian Order hopes that when this
11 legislation is enacted consideration will be given to
12 including home visiting nursing service. The Order is
13 vitally interested in the provision of adequate nursing
14 care for the sick at home and would be willing to draw
15 on its experience and knowledge of visiting nursing to
16 assist in the planning for these services for the people
17 of Saskatchewan.

16 THE CHAIRMAN: Thank you, Mr. Malden. Do any
17 of those associated with you have any comments they may
18 wish to make at this time?

18 MR. MALDEN: I don't believe so, but we would
19 welcome discussion and questions which would enable us
20 to elaborate further.

21 COMMISSIONER GIRARD: On page 2, paragraph
22 7 you state that in 1960 you had 3 percent more visits
23 than in 1959, and in the first ten months of 1961 you
24 had an increase of 12 percent in the number of visits
25 for the corresponding number of months: to what do you
26 attribute this large increase in the number of visits
27 between 1960 and 1961 -- to the new services?

27 MISS SWINTON: I think probably one of the
28 reasons is the new referral programme we developed in
29 one of our branches.
30



Since 1945 the provincial government has paid

each branch on a fee-per-visit basis for service to certain of its wards and certain cancer patients. In 1950, 25% of the total income in the four branches came from this source. In 1961 legislation was passed in relation to a program of medical care for all people in Saskatchewan. The Victorian Order hopes that when this legislation is enacted consideration will be given to including home visiting nursing services. The Order is vitally interested in the provision of adequate nursing care for the sick at home and would be willing to draw on its experience and knowledge of visiting nursing to assist in the planning for these services for the people of Saskatchewan.

Of those associated with you have any comments they may wish to make at this time?

Welcome discussion and questions which would enable us to elaborate further.

COMMISSIONER: (SARAO): On page 2, paragraph

7 you state that in 1950 you had a percent more visits than in 1949, and in the first ten months of 1961 you had an increase of 12 percent in the number of visits for the corresponding number of months. To what do you attribute this large increase in the number of visits between 1950 and 1961 -- to the new services?

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3 COMMISSIONER GIRARD: In Prince Albert?

4 MISS SWINTON: The Prince Albert branch, and
5 this has shown a remarkable increase. In that branch
6 there has been a 14 percent increase in volume of service
7 in the first ten months of 1961. In one of our other
8 branches we have a home care programme going. It is a
9 limited programme. It has approximately 12 patients, but
10 the volume of nursing these patients have required has
11 increased greatly during the year, the reason again being
12 these patients are rehabilitative problems -- patients
13 discharged from the rehabilitation department of the
14 Hospital of the University of Saskatoon. I think this
15 has contributed to the increase. There has been a general
16 increase in all the branches in 1961.

17 COMMISSIONER GIRARD: Miss Swinton, I know
18 this Home Care Programme in relation to rehabilitation
19 is something you have undertaken here, and I know the
20 V.O.N. has been active in rehabilitation in the last few
21 years. There has been a change-over in the case load,
22 and rehabilitation is one of the main functions; is that
23 right?

24 MISS SWINTON: Yes, it is.

25 COMMISSIONER GIRARD: Do you have many
26 branches that have home care programmes on the rehabi-
27 litation basis such as the one you are conducting now?

28 MISS SWINTON: In Saskatchewan?

29 COMMISSIONER GIRARD: I think Saskatchewan
30 is the only one, but I can't recall of any other we have
heard so far in the V.O.N. briefs in connection with
rehabilitation particularly.

MR. SWINTON: The Prince Albert branch, and

this has shown a remarkable increase. In that branch there has been a 14 percent increase in volume of service in the first ten months of 1961. In one of our other branches we have a home care programme going. It is a limited programme. It has approximately 12 patients, but the volume of nursing these patients have required has increased greatly during the year, the reason again being these patients are rehabilitative problems -- patients discharged from the rehabilitation department of the hospital of the University of Saskatchewan. I think this has contributed to the increase. There has been a general increase in all the provinces in 1961.

This home care programme in relation to rehabilitation is something you have undertaken here, and I know the V.O.W. has been active in rehabilitation in the last few years. There has been a change-over in the case load, and rehabilitation is one of the main functions; is that

MR. SWINTON: Yes, it is.

COMMISSIONER GIBBARD: Do you have many

approaches that have home care programmes on the rehabilitation basis such as the one you are conducting now?

MR. SWINTON: In Saskatchewan?

COMMISSIONER GIBBARD: I think Saskatchewan

is the only one, but I don't recall of any other we have heard so far in the V.O.W. briefs in connection with rehabilitation particularly.



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MISS SWINTON: This is the only organized home care programme where the emphasis has been placed on the rehabilitative opportunities.

COMMISSIONER GIRARD: Is this a pilot project, or is it a programme that is going to go on?

MISS SWINTON: Mr. Chairman, it is a pilot project, and it is in its last year. We hope it will continue.

COMMISSIONER GIRARD: Is it financed by the University Hospital?

MISS SWINTON: By Federal-Provincial grants.

COMMISSIONER GIRARD: In connection with that you have something very interesting also: this other home care project in relation to psychiatric patients. Has this started yet, or are you just in the planning stage?

MISS SWINTON: Mr. Chairman, this programme started as of January 1st 1962. It is a limited programme insofar as just a few patients have been admitted to it. How large it will be is something we have to see, but at the present time we have four to five patients. This is just since the first of the year. These patients are admitted to the programme and the Victorian Order is providing the nursing service in the home to the patient, and it is an organized home care programme with the same approach used for the rehabilitation programme. It is also centred in the same hospital and is under the direction of the Department of Psychiatry of the University Hospital of Saskatoon. It is primarily the same type of programme.

MISS SWINTON: This is the only organized
one case programme which the committee has been advised
on the rehabilitative opportunities.

ject, or is it a programme that is going to be done?
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continue.

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3 COMMISSIONER GIRARD: The service that your
4 nurses are giving, is it straight bedside care, or would
5 you have to choose nurses who had some special classes
6 in psychiatric nursing, or have done special studies in
7 psychiatric nursing, or is it simply bedside nursing home
8 care as in other programmes with the emphasis on psychi-
9 atric patients?

10 MISS SWINTON: Mr. Chairman, I think the
11 selection of nurses for a programme of this nature -- we
12 hope that most of our nurses have preparation in public
13 health nursing, and if they have, and especially are
14 recent graduates from the hospital schools of nursing,
15 they have preparation in psychiatric nursing, which
16 equips them to do this kind of work. We feel a well-
17 qualified public health nurse can manage this programme
18 very successfully. If additional instruction is needed,
19 it is done on an in-service basis provided by the branch
20 and using the consolidated services. But we don't feel
21 we have to have a special programme to train public health
22 nurses, that they should be equipped to move into this
23 programme and give good service to psychiatric patients.

24 COMMISSIONER GIRARD: So far what type of
25 patients did you get on this programme? By that, I
26 mean ambulant patients or bed-ridden patients?

27 MISS SWINTON: Mr. Chairman, I think these
28 patients are patients who have been admitted to the
29 general hospital for treatment, to the Psychiatric
30 Department of the University Hospital, and have had
treatment in the hospital. Some are ambulatory and some
part ambulatory and part in bed, but I think the feeling

COMMISSIONER CLARK: The services that your
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COMMISSIONER CLARK: So far what type of

patients did you put on this programme? By that, I
mean chronic patients or bed-ridden patients?

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3 was these were patients who would normally be discharged
4 to the North Battleford Hospital. They must be patients
5 from the Saskatoon area, and because no other arrangements
6 could be made they would have to go to the large insti-
7 tution, and they are being accepted at home as an experi-
8 ment to see if other conditions remain favourable, such
9 as housekeeping services and nursing if they could be
10 kept at home. I think there is a mixture of cases, but
11 nursing in this aspect is not the physical nursing of
12 so much general nursing care. A lot of this will be
supervision and instruction of the patient in the home.

13 COMMISSIONER GIRARD: So far the patients
14 you have, I understand your experience is limited and
15 you have only started recently, but have there been
16 patients living in their own home environment, or did
17 you have to use homemakers in the homes, or what type of
situation were they in?

18 MISS SWINTON: Mr. Chairman, I think most of
19 the patients admitted to the programme were patients
20 where home conditions could not be used unless these
21 auxiliary services were available. Either the patient
22 could not function as the homemaker in the home, or the
23 home would not be suitable without additional services
24 such as homemakers services, and so on. They have come
25 from the community but they could not go back to the
community without these additional services.

26 COMMISSIONER GIRARD: It is your impression
27 if you didn't have these services these patients would
28 be occupying beds in a psychiatric hospital?

29 MISS SWINTON: Yes.
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if you didn't have these services these patients would be occupying beds in a psychiatric hospital?

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4 COMMISSIONER GIRARD: So this could prove
5 that with the home care programme that you can give that
6 you can release those beds in these hospitals that are
7 overcrowded that we have heard about and make room for
8 other patients?

9 MISS SWINTON: That is correct.

10 COMMISSIONER BALTZAN: Perhaps you can clarify
11 this: on page 1, when the Provincial Government assumed
12 responsibility for health services the Victorian Order
13 withdrew from these activities: does that refer back to
14 1919, or is it of a recent date? I am just a little
15 mixed up?

16 MR. MALDEN: No; that refers to the dis-
17 continuance of the cottage hospitals.

18 COMMISSIONER BALTZAN: As of years ago?

19 MR. MALDEN: Yes.

20 COMMISSIONER BALTZAN: Then, "In 1919, to
21 avoid duplication of service, the Victorian Order with-
22 drew from the cottage hospital project and discontinued
23 rural district nursing in Saskatchewan." What dupli-
24 cation was there? You had enough nursing service under
25 the union hospital system when the Government took over
26 and there was no need for the Victorian Order of Nurses'
27 assistance then? What does that mean on page 1?

28 MISS SWINTON: Mr. Chairman, I think the
29 cottage hospitals were started from funds which were
30 raised outside of the Province to demonstrate the need
for hospital services in rural Saskatchewan, and that
the Union Hospital Act of 1917, the municipalities as-
sumed the responsibility to finance and build municipal



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hospitals, so the Victorian Order withdrew from the Hospital Plan because the monies that were being secured to finance these hospitals were coming from voluntary sources and it then became a municipal responsibility to build the hospitals.

COMMISSIONER BALTZAN: And they supplied their own nurses?

MISS SWINTON: Yes.

COMMISSIONER BALTZAN: On page (i) Paragraph 2, "At present four branches in Saskatchewan provide visiting nursing service to 28 percent of the population of the Province." 28 percent of the total population -- not the sick population?

MR. MALDEN: No; the total provincial population.

COMMISSIONER BALTZAN: How many Victorian Order nurses are there in these four branches today?

MR. MALDEN: Seventeen.

THE CHAIRMAN: And three part-time?

COMMISSIONER GIRARD: And nine qualified.

THE CHAIRMAN: What is your situation with regard to recruitment of V.O.N. nurses for your needs?

MRS. ROSS: I can only speak for Saskatoon and we have never had to recruit a nurse, we have always had applications on file. To get people with the public health is a problem because there are not adequate girls trained in public health but we have never had any difficulty in filling our vacancies.

THE CHAIRMAN: Taking them from some other branch of nursing?



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 Hospital Plan because the notice that was being issued
 to finance these hospitals were coming from voluntary
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 build the hospitals.

own money?

MISS ELLIOTT: Yes.

COMMISSIONER RALPH: Now on the financial

2, 14 percent from Province to Government provide
 visiting nursing service to 18 percent of the population
 of the Province." 23 percent of the total population --
 not the sick population?

MR. RALPH: Yes; 11-12 percent

population.

COMMISSIONER RALPH: Now many Victorian

Order nurses are there in these four branches today?

MR. MALCOLM: Seventeen.

THE CHAIRMAN: And three part-time.

COMMISSIONER GILMAN: And one qualified.

THE CHAIRMAN: What is your situation with

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 ficulty in filling our vacancies.

THE CHAIRMAN: Taking them from some other

branch of nursing?



MRS. ROSS: We are not taking them, they are coming.

COMMISSIONER GIRARD: May I ask, do you have any bursaries other than the National office, do you have any local bursaries for the training of nurses?

MRS. ROSS: The Provincial government has a bursary, four bursaries of \$250. each.

THE CHAIRMAN: That is for public health nurses?

MRS. ROSS: Yes, in the Province.

THE CHAIRMAN: Are they conditional?

MRS. ROSS: On one year service.

THE CHAIRMAN: In Saskatchewan after accepting the bursary?

MRS. ROSS: Yes.

THE CHAIRMAN: Do you find that deters the acceptance of bursaries?

MR. MALDEN: I believe we had more applications for bursaries last year than we could handle.

THE CHAIRMAN: The mere fact they were asked to stay and work in the Province does not prevent them from seeking the bursary?

MR. MALDEN: No.

MISS SWINTON: We have one bursary from the Government of Saskatchewan for a nurse in Saskatchewan on the understanding she would be employed in the Province when she completes her studies. We have four bursary students at the University of Saskatchewan this year and three of them have been placed by the National office.



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COMMISSIONER CLARK: May I ask, do you have

any business other than the National office, do you

have any local business for the training of nurses?

MRS. ROSS: The Provincial Government has a

library, four libraries of \$250. each.

THE CHAIRMAN: That is for public health

nurses?

MRS. ROSS: Yes, in the Province.

MRS. ROSS: On one year service.

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MRS. ROSS: Yes.

THE CHAIRMAN: Do you find that before the

acceptance of business?

MR. MADDEN: I believe we had some appli-

cations for business last year than we could handle.

THE CHAIRMAN: The more that they were asked

to stay and work in the Province does not prevent them

from seeking the business?

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4 COMMISSIONER McCUTCHEON: They have no strings
5 tied on them?

6 MISS SWINTON: One year of service.

7 THE CHAIRMAN: With the Victorian Order of
8 Nurses?

9 MISS SWINTON: Yes.

10 COMMISSIONER McCUTCHEON: Any place in Canada?

11 MISS SWINTON: That is right.

12 COMMISSIONER VAN WART: On page 2 of your
13 summary, Section 6, in 1961 legislation was passed in
14 relation to the programme of medical care for all people
15 in Saskatchewan. The Victorian Order hopes that when
16 this legislation is enacted consideration will be given
17 to including home visiting nursing services. Are you
18 visualizing the Victorian Order Nurse entering into the
19 medical care scheme or is that a general statement that
20 home visiting nursing care will be part of the plan?

21 MR. MALDEN: We hope the Victorian Order of
22 Nurses will enter into the plan and there are plans in
23 the United States which we think can be followed and
24 adopted in Saskatchewan. I think Miss Swinton would be
25 more able to elaborate on that.

26 MISS SWINTON: I think here in our submission
27 to the Advisory Planning Committee last year we did sug-
28 gest that in a programme of medical care visiting nurses
29 were an essential part and we would hope the Victorian
30 Order of Nurses would be included in the plans of
Saskatchewan where we are presently organized and if
invited we would be interested in organizing in other
sections. I think Mr. Malden is referring to the fact



COMMISSIONER McCUTCHON: They have no strings

attached on them?

MISS SWINTON: One year of service.

Nurses?

MISS SWINTON: Yes.

COMMISSIONER McCUTCHON: Any place in Canada

MISS SWINTON: That is right.

COMMISSIONER VAN WAT: On page 2 of your

summary, Section 5, in 1981 legislation was passed in relation to the programme of medical care for all people in Saskatchewan. The Victorian Order hopes that when this legislation is enacted consideration will be given to including home visiting nursing services. Are you vi- visiting the Victorian Order Nurses entering into the medical care system or is that a general statement that home visiting nursing care will be part of the plan?

MR. WALDEN: As for the Victorian Order of

Nurses will enter into the plan and there are plans in the United States which we think can be followed and adapted in Saskatchewan. I think Miss Swinton would be more able to elaborate on that.

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Order of Nurses would be included in the plans of Saskatchewan where we are presently organized and if invited we would be interested in organizing in other sections. I think Mr. Walden is referring to the first



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4 that it need not be a be all and end all proposition but
5 that visiting can be done in various manners. There are
6 ways in which the voluntary agencies and other agencies
7 get together for visiting and we would be interested in
8 any plans that would include the Victorian Order visit-
9 ing nursing in the plans for medical care in the Province
of Saskatchewan.

10 COMMISSIONER VAN WART: Do you visualize the
11 voluntary nature of your work being eliminated under
12 such a scheme?

13 MISS SWINTON: This would remain to be seen
14 but we feel if the voluntary agency has control of their
15 policy and policy-making and the administration of their
16 finances it is not too important where the money comes
17 from. As long as we retain our autonomy in this regard
18 we can function as voluntary agents within the total
context of medical nursing.

19 THE CHAIRMAN: On a compulsory medical ser-
20 vice programme?

21 COMMISSIONER VAN WART: Do you visualize be-
22 ing a voluntary agency outside of any government nursing
23 service that you would employ, so to speak, by the
24 Government for nursing service you would not be part of
25 it, you would retain your own autonomy of a volunteer
nature?

26 MISS SWINTON: If we entered into this in
27 the spirit of a combined agency, and that is what they
28 call this programme in the United States, it can be done
29 and it has been done with a volunteer agency working
30 under the umbrella of a community health service. The



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that visitation can be done in various manners. There are
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WAL WITT: Do you visualize the
voluntary agencies doing work which is not under
such a banner?

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4 volunteer agency is a separate entity, the public service,
5 the final service can through co-operation exist as one
6 health service for the community. This has been done.

7 COMMISSIONER VAN WART: Is it not one of
8 your fundamental principles that you only enter into a
9 community when you are asked by the community to go into
10 that community?

11 MISS SWINTON: That is true of the community
12 as such or any other agency or any other group than a
13 governmental group. Anyone who requests the service we
14 will investigate it.

15 COMMISSIONER VAN WART: Your order never
16 enters a community unless you have been invited to go
17 into the community?

18 MISS SWINTON: That is true.

19 COMMISSIONER VAN WART: Well, would you visu-
20 alize under a medical care plan you may be sent to a
21 community by the government for nursing care?

22 MISS SWINTON: Mr. Chairman, I do not know
23 that a voluntary agency can be sent because the voluntary
24 agency depends on the support both financial and -- sup-
25 port of the citizens in the community and unless the
26 community was prepared for the voluntary agency I do not
27 see how we could function in that context.

28 COMMISSIONER VAN WART: In other words, your
29 association with the Medical Care Service is a very
30 loose one?

MISS SWINTON: Well, at the moment we have
no association because we do not know --

COMMISSIONER VAN WART: You state that you



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4 hope you will be associated with it?

5 MISS SWINTON: I think probably our feeling
6 was that there is no reason why the volunteer agency
7 could not continue to exist as such in a comprehensive
8 medical care plan. We would hope that we would be asked
9 to remain as a nursing service in the plan for medical
care.

10 COMMISSIONER VAN WART: The volunteer agencies
11 in the health field have done a wonderful work over the
12 years and I ask this because I think it would be a shame
13 to see your order lose its voluntary identity by becoming
14 part and parcel of a larger scheme. That is the reason
15 why I have asked these questions, whether you thought
16 out the implications of your suggestion here to become
part of the medical care nursing system.

17 MISS SWINTON: I think our feeling is not
18 so much becoming a part of it as co-operating with the
19 programme, that we have certain resources in the Prov-
20 ince of Saskatchewan both in the personnel and in our
21 services that we are offering and we feel that these
22 services would need to be retained and added to if home
23 care services were going to be extended in the Province.
24 Quite frankly we do not feel that the Province could
25 offer the service that the Victorian Order is providing
now.

26 COMMISSIONER McCUTCHEON: Is it a fair state-
27 ment that the hospital medical care bill is the only nursing
28 services that are contemplated under any legislation in
29 the Province of Saskatchewan in hospital nursing service is
30 by and large the Victorian Order except for having a



...you will be associated with it?

MR. ALLEN: I think, because of our feeling

was that there is no reason why any voluntary agency
could not continue to exist as such in a comprehensive
medical care plan. We would hope that we would be asked
to remain as a nursing service in the plan for medical

GOVERNOR: I think that the volunteer agency

in the medical field, we have a wonderful work over the
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to see your organization lose its voluntary identity by becoming
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GOVERNOR: I think it is a fair state-

ment that the hospital medical care still is the only medical
service that has been established under any legislation in
the Province of Saskatchewan in hospital nursing service
by and I am sure the Victorian Order except for having a



nurse for a furlough, for their home care programmes there is no in-hospital service, am I right?

MISS SWINTON: That is true.

COMMISSIONER McCUTCHEON: So you are saying no more, are you, than that you have been paid on a fee for service basis by the Provincial Government since 1945 for certain home care nursing services to provide and you would hope this would be continued and you would hope for a home care programme to be extended. There is no evidence that the Province is going to do that but if it was that you would be included in it; is that what you mean?

MISS SWINTON: Yes.

COMMISSIONER VAN WART: On a voluntary basis?

COMMISSIONER STRACHAN: On page 2, paragraph 5 I note where you have extended your service to include the Air Force base outside of the city limits in Saskatoon and Moose Jaw. Is that for service personnel dependents and is it done right on the base?

MISS SWINTON: That is true. The service is taken to the permanent housing areas provided by the Air Force at these two bases.

COMMISSIONER STRACHAN: What type of service is rendered there particularly?

MISS SWINTON: This service would be the same as any other service that we have in the city branch that approximates these bases. It is the straight home nursing services, bedside nursing services with sick at the home and education visits to the new mothers and infants and new-born babies and so on.



nurse for a full-time, for their home care program
 there is no in-hospital service, or night
 MISS WILSON: That is true.

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 the home and education visits to the new mothers and
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4 COMMISSIONER STRACHAN: You would deal with
5 entirely young people, that is a certainty?

6 MISS SWINTON: Yes.

7 COMMISSIONER STRACHAN: You would at no time
8 be rendering any service to the service personnel?

9 MISS SWINTON: Again, if the service person-
10 nel were in his home he would receive the service the
11 same as any other member of his family. This service is
12 offered to these permanent housing areas on the same
13 basis as any other resident and any other community and
14 the total number of a family would receive these services
15 if there is an illness there. The Armed Services
16 may have medical service on the base for the Armed forces
17 but it is not taken into the family home and so we pro-
18 vide this service in the home.

19 COMMISSIONER STRACHAN: If the service medi-
20 cal officer permits that individual to stay in the home?

21 MISS SWINTON: That is correct.

22 THE CHAIRMAN: What do you do to expand the
23 degree of your services, the area of your services in the
24 community where you are established?

25 MR. MALDEN: It is mostly a case of bringing
26 our name before the public. Every day we run into people
27 on the street that are introduced to a V.O.N. service
28 that they did not know existed. It is largely a matter
29 of educating the public to these services that we do
30 offer so reasonably.

THE CHAIRMAN: How is that done? What is
this educational process?

MR. MALDEN: We have T.V. spots, radio spots,

COMMISSIONER STANLEY: You would deal with

entirely young people, that is a certainty?

COMMISSIONER STANLEY: You would at no time

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COMMISSIONER STANLEY: Is the service medical or other parties that individuals to stay in the home?

MR. LAMSON: That is correct.

THE CHAIRMAN: What do you do to expand the degree of your services, the area of your services in the community where you are established?

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THE CHAIRMAN: How is that done? What is

this educational process?



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3 newspaper spots and a publicity chairman in the local
4 branch. This Saskatchewan branch has not carried on any
5 publicity campaign to date. Each local branch carries
6 its own, sometimes efficiently and sometimes not too
7 efficiently. We also make sure that the new mothers
8 leaving hospital are acquainted with the services of the
9 organization.

10 THE CHAIRMAN: How is that done?

11 MR. MALDEN: Through pamphlets inserted in
12 a mother's book as they leave. We are constantly speaking
13 to doctors hoping to induce them to refer patients to the
14 V.O.N. when it is needed.

15 THE CHAIRMAN: Have you indication that be-
16 cause of V.O.N. services being available to those who
17 leave hospitals that it may shorten the stay of the
18 patient in the hospital?

19 MR. MALDEN: Yes, they do.

20 THE CHAIRMAN: To what extent? Would you
21 develop that a bit?

22 MR. MALDEN: I could not, I do not know any
23 percentage.

24 THE CHAIRMAN: I am not talking necessarily
25 about percentages but some suggestion about the extent
26 to which you believe it might accomplish that fact.

27 MR. MALDEN: We do know there are patients
28 desirous of getting back with their family that could
29 not do so without V.O.N. service.

30 THE CHAIRMAN: They would have to stay in
the hospital?

MR. MALDEN: Yes.

newspaper news and a publicity chairman in the local branch. This Saskatchewan branch has not carried on any publicity campaign to date. Each local branch carries its own, sometimes efficiently and sometimes not too efficiently. We also make sure that the new mothers leaving hospital are acquainted with the services of the organization.

THE CHAIRMAN: How is that done?

MR. MALLIN: Through pamphlets inserted in a mother's book as they leave. We are constantly asking to doctors hoping to induce them to refer patients to the O.N. when it is needed.

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cause of V.O.V. services being available to those who leave hospital that it may shorten the stay of the patient in the hospital?

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4 MISS SWINTON: I think it is significant in
5 our increase in service we notice there seems to be a
6 relationship between the shortage of beds in the hospital
7 as to our increase in service to that particular branch.
8 If there has been, for one reason or another, pressure
9 on the hospital utilization for a period of time it is
10 reflected usually in the number of referrals that we get
11 of the more acutely ill. In other words, services go in
12 that stage and the convalescents, the patients in that
13 set of circumstances their stay is shortened when there
14 is pressure for a bed.

15 THE CHAIRMAN: There is necessarily a charge
16 for your services, you are operating on a fee-for-service
17 basis?

18 MISS SWINTON: That is right.

19 THE CHAIRMAN: Have you had any indication
20 from the fact that hospitalization was being paid for
21 in advance that the patient does not have to pay for it
22 if he stays an extra day in the hospital, if that has
23 had any bearing on the situation of staying in the hospi-
24 tal so far as you are concerned?

25 MISS SWINTON: I think we would have to agree
26 that this is the case. Lately we have noticed there
27 seems to be an increase in the type of patient we are
28 admitting for service. It seems we serve two main clas-
29 sifications, the well to do and the indigent, because
30 neither of these two classifications have too much
trouble as far as the fee-for-service is concerned; the
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in our brief, payment is made by the Government for



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from the fact that hospitalization was being paid for
in advance that the patient does not have to pay for it
if he stays an extra day in the hospital, if that has
had any bearing on the situation of staying in the hospital?
Did you have any concern?

MR. SWINTON: I think we would have to agree

that that is the case. Later we have noticed there
seems to be an increase in the type of patients we are
admitting for service. It seems we serve two main classes
of patients, the well to do and the indigent, because
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in our brief, payment is made by the Government for



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certain wards of the Government so there is no cost involved to this patient. We are getting increasingly more of these patients but we are losing numbers in the middle-class group where these arrangements are not made.

THE CHAIRMAN: Do you think that indicates they are staying in the hospital longer because the hospitalization is paid for?

MISS SWINTON: This feeling has been quoted to us.

THE CHAIRMAN: Do you accept that as being a feeling for which there is some foundation?

MISS SWINTON: Yes, we do.

COMMISSIONER GIRARD: In relation to this, Miss Swinton, on page 10 there is mention that only 21 percent of cases visited by the V.O.N. in 1960 have been in hospital. Is this an increase over the previous years? It means that about one-fifth of your patients have been in hospital so that is the number that you get over from referrals or from home care programmes. Is this number, is this 21 percent higher than it was before you had this referral system and the home care programmes?

MISS SWINTON: This increase in 1960 is only 1 percent over the previous year. In 1961 we instituted this referral programme and in the Prince Albert area we are working on another department. There are differences in Saskatchewan, in one branch the rate of referrals of 45 percent of all the cases are hospital referrals and in another branch there was something like 10 percent. There seems to be a local problem here. We feel that this is again in relation to the hospital



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certain parts of the Government as there is no great in-
volved in this matter. We are getting increasingly
more of these patients but we are feeling uneasy in the

the treatment of you with that individual
they are staying in the hospital longer because the
hospitalization is paid for.

MISS BUCHANAN: These people are being placed
to us.

THE CHAIRMAN: Do you suggest that we bring
a feeling for what we are doing?

MISS BUCHANAN: Yes, we do.
LAWSON: I think it is better to have

Miss Buchanan, or we are in a position that only 21
percent of cases are being treated in 1950 have been

in hospital. This is in contrast to the previous
years. It means that about one-third of your patients

have been in hospital, so that is the number that you put
over from before. Do you have any explanation, is

this number, in 1951, about 21 percent when it was before
you had this national system and the case program?

MISS BUCHANAN: This increase in 1950 is only
1 percent over the previous year. In 1951 we instituted

this national program and in the Prince Albert area
we are working on another department. There are dif-

ferences in Saskatchewan, in one branch the rate of
referrals of 25 percent of all the cases are hospital

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We feel that this is again in relation to the hospital



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3 utilization; if there seems to be a shortage of beds we
4 get more hospital referrals and if there is not this
5 shortage of beds we do not get many.

6 COMMISSIONER GIRARD: You feel 21 percent is
7 low? It could be much higher than that?

8 MISS SWINTON: That is very low, we feel it
9 is lower than our national average.

je 10 COMMISSIONER GIRARD: Miss Swinton, on page
11 2, no. 5, there is also something here I think. The V.O.N.
12 has been offering for a number of years now, in different
13 branches, service to industry, and it seems to me that
14 the different V.O.N. briefs that I have been reading the
15 last few months, every branch seems to think that there
16 is a lot of room for improvement in this service. Do
17 you have any idea why this service has not spread more
18 than it has, and this is not just here in Saskatchewan,
19 it is the trend. Most of the briefs have said this.
20 You have two industries I believe that you are serving?

21 MR. MALDEN: Yes.

22 MISS SWINTON: Mr. Chairman, I think this is
23 again something, that the programme has to be accepted
24 by the industry as being worthwhile, and in most of the
25 industries the age group is this middle group where per-
26 haps the incidence of illness is not great. We seem to
27 be serving the very young and the very old, and we are
28 not serving too many in this middle age group, and the
29 industry has to contract for this service, and more in-
30 dustries are employing their own staff, but we feel it
could be a programme to develop from the teaching and
counselling point of view for the middle aged or the



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4 working group population. I don't think we have really
5 tried to develop it, because in our priorities, the home
6 nursing has really had the greatest emphasis.

7 COMMISSIONER GIRARD: But don't you agree
8 that this is the group the people in public health de-
9 plore that they cannot reach. You reach the pre-school
10 child, you reach the school child until he leaves school,
11 and then you reach the young mother at her first baby,
12 but you don't reach the male adult very much, this is
13 a group that seems to slip out of our hands in public
14 health, and this is one way that this group could be
15 reached, and it is done very well when it is done.

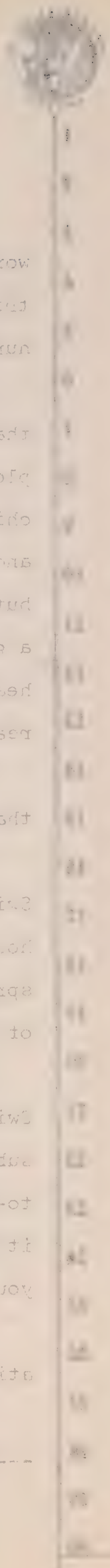
16 MISS SWINTON: Mr. Chairman, we agree with
17 that.

18 COMMISSIONER BALTZAN: Just one word, Miss
19 Swinton. I am just a little bit disappointed. I had
20 hoped to hear from you that the doctors ranked no. 1 to
21 spread your name and your fame. That is my estimation
22 of your work, the Victorian Order of Nurses.

23 THE CHAIRMAN: Thank you, Mr. Malden, Miss
24 Swinton, and ladies. We are grateful to you for your
25 submission, and for your assistance and attendance here
26 to-night. We are sorry that we have kept you back, but
27 it was just one of those things. We are obliged that
28 you have been so good-natured about it.

29 The Saskatchewan Registered Nurses' Associ-
30 ation. This brief will be Exhibit No. 84.

----EXHIBIT NO. 84: Submission of the Saskatchewan
Registered Nurses' Association.



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The Saskatchewan Registered Nurses' Associa-
tion. This order will be Exhibit No. 34.



SUBMISSION OF THE SASKATCHEWAN REGISTERED NURSES'
ASSOCIATION

APPEARANCES:

Miss Myrtle Crawford
Chairman, Committee on
Nursing Education.

Miss Patricia McGrath
President

Miss Caroline Dauk
Chairman, Committee on
Nursing Service

Miss Louise Miner
Immediate Past President

Miss Dorothy Hibbert
Member

THE CHAIRMAN: Who is the spokesman?

MISS CRAWFORD: I am Myrtle Crawford, Mr. Chairman, and with me are Miss Caroline Dauk, a member of our Council; Miss Dorothy Hibbert, a member of our Association; Miss Patricia McGrath, the President of our Association; and Miss Louise Miner, the Immediate Past President of our Association.

In introduction, I would like to say that the Saskatchewan Registered Nurses' Association believes that comprehensive health care should be available to all residents of Saskatchewan. It believes that health care should include preventive, diagnostic, therapeutic and supportive professional services; this should be provided



APPARANCES

Miss Myrtle Crawford,
Chairman, Committee on

Miss Patricia McCreath
President

Miss Caroline Dark
Chairman, Committee on
Nursing Service

Miss Louise Miller
Immediate Past President

Miss Dorothy Hibbert

THE SPEAKER: And in the speaker's

MISS CRAWFORD: I am Myrtle Crawford, Mr.

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the Saskatchewan Registered Nurses' Association believes

that comprehensive health care should be available to all

residents of Saskatchewan. It believes that health care

should include preventive, diagnostic, therapeutic and



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4 through facilities for health education and health super-
5 vision, early diagnosis and treatment in hospital and
6 home including rehabilitation. As nursing care is an
7 essential component of such coverage and its provision
8 is the responsibility of the nursing profession, we wel-
9 come the opportunity to present this brief to the Royal
Commission on Health Services.

10 Plans for the provision of a variety of health
11 services have long been gathering momentum in Saskatchewan.
12 A careful and painstaking assessment of the contributions
13 which nursing is able to make to health care has during
14 this same period been the specific concern of the Sask-
atchewan Registered Nurses' Association, or the S.R.N.A.

15 In the preparation of this brief for pre-
16 sentation to the Royal Commission on Health Services for
17 Canada, the S.R.N.A. has undertaken to organize and
18 analyze the wealth of material which has been accumulated
19 and on the basis of their findings, has attempted to chart
20 a course for the future which should ensure that the
21 best possible nursing care is available to all people in
22 Saskatchewan. A synopsis of the proposals is appended
herewith.

23 The following conclusions and recommendations pertain
24 to terms of reference:

- 25 b) Methods of improving existing health services,
26 c) The correlation of any new or improved program
27 with existing services, with a view to providing
28 improved health services, and
29 d) The present and future requirements of personnel
30 to provide health services.



vision, early diagnosis and treatment in hospital and home including rehabilitation, so nursing care is an essential component of such coverage and the provision is the responsibility of the nursing profession, we welcome the opportunity to present this paper to the Royal Commission on Health Services.

There is the question of a variety of health services at a local level, especially in Saskatchewan. A careful and careful assessment of the conditions which nursing is to be required to deal with has been made. This has been done in the context of the work of the Saskatchewan Registered Nurses' Association, on the S.F.N.A. and the International Council of Nurses for example.

Attention to the work of the International Council of Nurses, the I.C.N., is also relevant to our work and the work of nursing which has been acknowledged and on the basis of which, as attempted to chart a course for the future, we would argue that the best possible nursing care is available to all people in Saskatchewan. A review of the work of the I.C.N. is appended herewith.

The following recommendations and recommendations contain a number of references to the work of the I.C.N. and the work of nursing which has been acknowledged and on the basis of which, as attempted to chart a course for the future, we would argue that the best possible nursing care is available to all people in Saskatchewan. A review of the work of the I.C.N. is appended herewith.

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The S.R.N.A. has reached the conclusion that reliable data, related to the nursing care needs of patients, is a prerequisite to sound long-range planning. In order to ensure that desirable standards of nursing care can be provided, THE FOLLOWING RECOMMENDATION IS MADE:

I recommend That the Royal Commission on Health Services for Canada support a study to determine the quantity and quality of nursing care required by patients with different medical and dependency needs and in varying situations, so that reliable up-to-date information will be available:

- a) to plan realistically to meet needs for nursing care
- b) to clarify functions and the needs for the various categories of nursing personnel. (This group includes graduate nurses, psychiatric nurses, nursing assistants, nurses aides, orderlies, technicians, attendants.)
- c) to develop appropriate educational programs to prepare such personnel to carry out their functions.

A suggested outline for such a study is shown in Appendix VII.

Since the demand for nursing care continues to exceed the supply, and since the effects of shortage of personnel may be intensified in certain agencies and show marked seasonal fluctuations, the S.R.N.A. records its concern that the standards of care may fall below minimal safety levels. WE THEREFORE WISH TO RECOMMEND:

II That overall planning be carried out on a



province-wide basis to make the best use of available facilities and personnel. Some of the smaller hospitals which cannot be adequately staffed to give safe care should not admit acutely ill patients. These hospitals should be adapted to other purposes and might be used as one step in the progressive care of convalescent patients from the larger hospitals to the home. Consideration should be given to the utilization of suitably located smaller hospital units for the aged and for persons with long-term illness. This would enable these patients to remain in their own communities.

III That nurse representation be ensured at all levels of planning so that nursing services will keep pace with any expansions of health services.

IV That the organization of health services be planned so that directors of nursing have authority commensurate with their responsibility for providing nursing service.

V That the number of qualified public health nurses allocated to a health region be increased for the present to a ratio of 1 nurse to 3,000 population, and that an analysis be carried out that will determine the most effective number and ratio of nursing staff required to carry out the functions expected of them in the developing public health programs.

VI That recruitment and preparation of public health nursing personnel be given high priority in the forward planning for expansion of health services.

VII That administrators of hospital services be encouraged to take steps to limit the admission of



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facilities and personnel. Some of the smaller hospitals
which cannot be adequately staffed to give safe care
should not accept seriously ill patients. These hospitals
should be referred to other hospitals and might be used
as one step in the hospital care of convalescent
patients from the larger hospitals to the home. Con-
sideration should be given to the utilization of suit-
ably located medical hospital units for the aged and for

patients to receive their own communities.
11. The nurse's responsibility should be expanded to all
levels of care so that nurses as well as physicians
and other health workers will be able to provide
the organization of health services so
planned so that the needs of the community are adequately
met. This responsibility for providing
nursing services.

12. The number of qualified public health
nurses allocated to a health unit should be increased for
the present to a ratio of 1 nurse to 1,000 population,
and that as the ratio is lowered it will be determined
by the need for health services and the training of nursing staff.
13. The health services should be expanded to
include the development of health programs.
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include the development of health programs.



patients for elective care to those hospitals where qualified nursing staff is available so that safe and acceptable standards of nursing care can be maintained.

VIII That methods be studied whereby increased use of centralization and automation may be provided for certain indirect nursing activities. This should not however interfere with the nurse-patient contact.

IX That nurses be given the opportunity to evaluate and contribute suggestions related to the planning and equipping of nursing units prior to construction.

The following conclusions and recommendations pertain to terms of reference

e) Methods of providing adequate personnel with the best possible training and qualifications for such services.

In reviewing the whole picture of the preparation of nursing personnel in Saskatchewan, it has become increasingly evident that radical changes in the educational programs are required and these should be given priority in improving or extending health services. We are convinced that the responsibility for all nursing education should be removed from agencies whose main responsibility is service and be placed within the jurisdiction of independent institutions whose main concern is education. WE THEREFORE RECOMMEND:

X That two separate and distinct types of programs for the preparation of professional nurses be established for high school graduates in Saskatchewan:



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qualified nursing staff is available so that safe and
acceptable standards of nursing care can be maintained.
VII That methods be studied whereby increased
use of centralization and automation may be provided for
certain indirect nursing activities. This should not

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The following are the jobs and recommendations
pertaining to terms of reference

e) Methods of recruitment of nursing personnel with
the best possible training and placement options for such

f) Reviewing the whole range of the pro-
cesses of nursing personnel in Saskatchewan, it has
become increasingly evident that major changes in the
educational programs are required and these should be

given priority in approving or extending health services.
It is recommended that the responsibility for all nursing
education should be removed from agencies whose main
responsibility is service and be placed within the

Ministry of Education. It is recommended that the main
concern is education. WE 10-10-60 (10-10-60)

X That two separate and distinct types of
programs for the preparation of professional nurses be
established for high school graduates in Saskatchewan:



a) A four-year University-based program leading to a baccalaureate degree in nursing, intended to prepare the graduates for leadership positions in nursing

b) two-year independent programs leading to a diploma in nursing intended to prepare hospital staff nurses.

XI a) That independent regional schools of nursing offering two-year programs be established (two in the northern part of the province and two in the southern part of the province) to replace the present hospital schools of nursing. This pattern could allow for a continuation of the interests of the Roman Catholic Sisterhoods who might sponsor one or more independent schools.

b) That clinical nursing experience be arranged with hospitals and other agencies located in areas readily accessible to these centres.

XII That clinical facilities in hospitals and health agencies continue to be available to nursing students but in a manner similar to that now used for medical students.

XIII That the controlling body of these two-year programs be representative of such groups as: the administrators, nursing directors and members of boards of management of participating agencies; the administration of the University of Saskatchewan; the Department of Public Health, Province of Saskatchewan; the Saskatchewan Hospital Association; the Catholic Hospital Conference; the Saskatchewan Registered Nurses' Association;



the College of Medicine, University of Saskatchewan; the Department of Education; Province of Saskatchewan; the faculty of the School of Nursing, University of Saskatchewan.

In order that sufficient teachers, administrators, clinical specialists and consultants will be available to make changes in the present pattern and to evaluate progress in the future, IT IS RECOMMENDED:

XIV That the faculty of the University of Saskatchewan School of Nursing be increased and its facilities extended so that:

- a) the existing degree program can be strengthened in order to ensure that the beginning graduate can function effectively at first level leadership positions in hospitals and public health agencies
- b) the total clinical experience of the undergraduate degree program will be under the direct control and supervision of the faculty
- c) the program may be extended beyond the baccalaureate level in order to prepare nurses as clinical specialists and consultants, for leadership positions in nursing service and nursing education and for research
- d) extension courses may be offered for graduates of present hospital schools which would provide depth in a clinical field.

XV That the value of continuing education be brought to the attention of both hospital and public health agencies and that they be encouraged to provide



opportunities for all nursing service personnel to participate in such programs.

Acceptance and development of an auxiliary group is a corollary to the extension of professional services to the public. Nursing has for some time included such groups, but considerable concern has been expressed about the rapid growth, lack of satisfactory pre-service training, and inadequate supervision of many of these auxiliary workers. WE THEREFORE RECOMMEND;

XVI. That nursing assistants continue to be prepared at the Canadian Vocational Training School in Saskatoon for a maximum of twelve months, and that the present curriculum and the expectation of the employing institutions be subject to continuous scrutiny in order that their activities not be extended beyond their preparation.

XVII. That men employed as orderlies to give patient care be required to prepare themselves as nursing assistants.

XVIII. That, since it appears there will be a sufficient number of nursing assistants available for auxiliary positions within the next five years, all categories of auxiliary personnel, (other than nursing assistants,) now providing direct patient care, be excluded from the nursing force.

The following conclusions and recommendations pertain to terms of reference

- i) the methods of financing any new or extended programs and
- j) proposals for nursing research.

opportunities for all members; and the personnel to

participate in such programs.

It is the policy of the Board of Directors

to provide a variety of opportunities for members

to participate in the program during the year and

to provide for the needs of the members and

to provide a program of continuing education for

XVI. That the Board of Directors shall continue to be

composed of members of the Board of Directors

and that the Board of Directors shall have the

authority to make such changes in the composition

of the Board of Directors as it may deem

advisable in the best interests of the

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XVIII. That the Board of Directors shall have the

authority to make such changes in the composition

of the Board of Directors as it may deem

advisable in the best interests of the

association and to make such other

changes as it may deem

The following constitution and bylaws are

submitted to the members of the

association for their consideration and

approval.

1) The Board of Directors shall have the



Since the S.R.N.A. proposes that nursing students no longer subsidize the cost of nursing education through their services, it is necessary to consider alternative methods of supplying staff to hospitals and of financing nursing education. WE THEREFORE RECOMMEND:

XIX That budgets for nursing service provide realistically for sufficient nursing staff to ensure quality patient care without dependence upon students.

XX That funds for the support of nursing education be made available directly to sponsors of independent schools of nursing.

XXI That bursary and loan funds be extended so that no suitable candidate need be prevented from preparing for a career in nursing because of financial considerations.

A lack of nurses prepared at the post-baccalaureate level could act as a deterrent to the implementation of the proposed educational program and to further study and research in nursing service and nursing education. WE FURTHER RECOMMEND:

XXII That funds from federal and provincial grants to education be made available to the University of Saskatchewan in order to prepare the necessary faculty for its School of Nursing at Master's and Doctoral levels.

No active research has ever been carried out and published in Canada on the learning process as it occurs in the clinical situation, where the teaching-learning of patient care takes place. It is obvious that present methods are not producing well qualified nurses who are highly competent in the planning



and implementation of patient care and who can guide and teach others. HENCE IT IS RECOMMENDED:

XXIII That financial assistance be made available from federal sources:

- a) to give continuing support to programs elsewhere in Canada presently experimenting with new methods of teaching - learning patient care
- b) to encourage universities to expand their faculties of nursing so that research activities related to nursing can be given an increased amount of time and attention.
- c) to permit exchange of ideas among those responsible for developing newer patterns of nursing education by providing funds to support conferences, work-shops, and observation visits.

Since staff morale is reflected in the quality of patient care provided and since one of the identifiable factors in staff morale is the establishment of satisfactory personnel policies, WE RECOMMEND:

XXIV That salary ranges for nurses providing direct patient care be so constructed as to permit greatly increased financial recognition for additional preparation and for quality service in the clinical areas.

XXV That the employing agencies be encouraged and enabled to remunerate nurses in positions of responsibility in a manner commensurate with their preparation and the responsibility inherent in the position.

In relation to term of reference

k) The feasibility and desirability of priorities in the development of health care services, we feel



and improvement of the patient and the staff and the community

XXIII. The patient's role in the health care process

1. The patient's role in the health care process is a dynamic one, changing as the patient's needs and the health care system evolve. The patient's role is defined by the patient's needs, the health care system, and the community.

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3 that the following recommendations should be
4 given priority:

5 Recommendation II

6 Recommendation VI

7 Recommendation VII

8 Recommendation X
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10 THE CHAIRMAN: Thank you, Miss Crawford. It
11 is obvious that your Association has given a great deal
12 of time and consideration to the preparation of this
13 brief, and to the formulation of your recommendations.
14 We know, of course, that you have supplemented your ob-
15 servations and your recommendations in the brief itself,
16 and by certain appendices appearing in the same document.
17 It may be of some value to us that we discuss your recom-
18 mendations perhaps in slightly more detail than you have
19 done in your opening summary, but before we do that, is
20 there anyone from your group who wishes to expand, or
21 add to what you have said at this stage?

22 MISS CRAWFORD: I think we have agreed that
23 I would speak for the group at the moment, and if there
24 are some of the questions, some of the further dis-
25 cussion, that you have referred to, I may refer these
26 questions to members of my group.

27 THE CHAIRMAN: You may answer as you see fit
28 as amongst yourselves.

29 How would you go about implementing the recom-
30 mendation no. 7, which is one of the recommendations that
you regard as deserving of giving it no. 3 priority, of
limiting the admission of patients for elective care to
hospitals where qualified nursing staff is available?



Who is going to be the judge? Who is going to be the policeman?

MISS CRAWFORD: We suggested administrators of hospital services. This might be the nursing administrator or the general administrator of the hospital -- either one of these.

THE CHAIRMAN: Assume now you are an administrator, and patients are admitted only by their physician. The physician sends a patient to the hospital: has the administrator any power to reject that patient if there is space available? Remember the patient has a card, if he has paid the premium; if the premium has been paid the patient will have a card entitling he or she to hospital service.

MISS CRAWFORD: Well, space available is only one of the services that the hospital has to offer. It offers also nursing care and also other services that go along with this, and if it cannot provide all of these services then our feeling is that the space is not really available.

THE CHAIRMAN: How are you going to do it, though? This is a practical thing.

MISS McGRATH: I think we have had instances, particularly during our summer months, where there is a reduced number of nursing staff available, and when this is brought to the attention of the administration who are as concerned normally as the director of nursing is about providing good patient care, there have been times when it has been necessary to call a Board meeting very suddenly, because that is where the final decision



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4 must be made, and they close down a certain number of
5 beds, and we allocate the available beds that can be
6 serviced adequately, always retaining a certain number
7 of beds for emergencies. But these are steps that have
8 been taken and are taken.

9 THE CHAIRMAN: You have to really suppress
10 the bed for the time being?

11 MISS McGRATH: Yes, and you are not waiting
12 until the patient arrives on the doorstep. This policy
13 is approved by the Board of Administration, so that while
14 the beds may be there, as far as usage is concerned they
15 have been excluded from the available beds in the in-
16 stitution.

17 THE CHAIRMAN: Is this done with the approval
18 of the Saskatchewan Hospital Services Commission?

19 MISS McGRATH: Yes.

20 COMMISSIONER McCUTCHEON: Would you correct
21 that situation if you had more money from the Commission
22 to provide reliefs?

23 MISS McGRATH: Not necessarily because it
24 is inability to get the staff.

25 MISS CRAWFORD: Sometimes budgets are not
26 adequate to provide for vacation coverage.

27 COMMISSIONER McCUTCHEON: That was the
28 question I asked: if you had more money could you find
29 the nurses to take care of this vacation situation?

30 MISS McGRATH: No, I don't believe so, be-
cause I think we all agree that during three months of
the year at least this is the time when people all want
their vacations, and while you try to spread it out



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3 over the twelve-month period it is very difficult to do,
4 and therefore you will find in this three months, you
5 will have a shortage of staff because of people re-
6 questing and taking holidays in this three months.

7 COMMISSIONER VAN WART: Is this for the patients'
8 good?

9 MISS McGRATH: For the patients' good.

10 COMMISSIONER VAN WART: Or is it as a result
11 of the shortening of nurses' hours in the hospital --
12 a shorter length of time on nursing duties?

13 MISS CRAWFORD: Do you mean has this situation
14 developed because of shortening of nurses' hours?

15 COMMISSIONER VAN WART: Yes.

16 MISS CRAWFORD: This is undoubtedly why it
17 takes more nurses -- one reason why; but the nurses'
18 hours are not any shorter than any other worker in the
19 hospital or other workers generally.

20 COMMISSIONER VAN WART: Would lengthening the
21 nurses' hours solve the problem for your temporary
22 emergency?

23 MISS CRAWFORD: It might, but as I indicated
24 earlier sometimes budgets do not allow money enough to
25 pay this much overtime pay.

26 COMMISSIONER VAN WART: You are getting back
27 to dollars and cents again; there is not enough money.

28 MISS HIBBERT: There is another major problem:
29 we must create a situation which encourages nurses to
30 stay with us, and with the ability to get employment
elsewhere this would not encourage them to stay.

THE CHAIRMAN: This kind of thing you are
talking about here, is it related to hospitals of a
certain size, or does it run...?



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4 MISS McGRATH: It is right across the board;
right through the whole gamut.

5 THE CHAIRMAN: Even in the largest hospitals?

6 MISS McGRATH: Yes.

7 MISS HIBBERT: Closely related to this is the
8 high turnover of nurses coming about the time vacations
9 start, and we don't catch up with that until the fall.

10 THE CHAIRMAN: Would you say beds were sup-
11 pressed in the five larger hospitals during the summer
months?

12 MISS CRAWFORD: Speaking for the University
13 hospital, last summer, yes. There were 100 beds closed.
14 This is the only large hospital.

15 THE CHAIRMAN: There were 100 beds, and was
16 there a list of those waiting for service?

17 MISS DAUK: Emergencies were admitted.

18 THE CHAIRMAN: And for elective service, there
19 would be a waiting list in the City of Saskatoon at that
time?

20 MISS DAUK: I am sure there would have been.

21 THE CHAIRMAN: And that is the way the University
22 hospital dealt with the situation, by suppressing 100
23 beds?

24 MISS DAUK: I believe it was the first time
25 last year.

26 THE CHAIRMAN: We come to your fourth recom-
27 mendation, recommendation no. 10, in which you recommend
28 a four year University based programme leading to a degree
29 in nursing. How many graduates a year have you in con-
30 templation in this recommendation?



right through the whole amount.

MISS MARY: Yes.

MISS MARY: Closely related to this is the

high turnover of nurses coming about the time vacations start, and we don't cater up with that until the fall.

THE CHAIRMAN: Would you say that was also

pressed in the two hospital hospitals during the summer months?

MISS MARY: Speaking for the University

hospital, that summer, yes. There were 100 beds closed.

This is the only large hospital.

THE CHAIRMAN: There were 100 beds, and was

there a list of nurses waiting for service?

MISS MARY: I believe so were admitted.

THE CHAIRMAN: And for elective service, there

would be a waiting list in the fall of 1934 at that

time.

MISS MARY: I am sure there would have been.

THE CHAIRMAN: And that is the way the University

hospital dealt with the situation, by supplying 100

beds.

MISS MARY: I believe it was the first time

last year.

THE CHAIRMAN: As to your fourth recom-

mendation, recommendation no. 10, in which you recommend

a four year University based program leading to a degree

in nursing. How many graduates a year have you in con-

templated in this recommendation?



MISS CRAWFORD: I believe we have indicated that at some point. We anticipated it is possible that 500 might graduate from the two-year programme.

THE CHAIRMAN: No; from the four-year programme?

MISS CRAWFORD: Oh, 125.

THE CHAIRMAN: 125 a year?

MISS CRAWFORD: Yes.

THE CHAIRMAN: That would mean that in any one year at the University there would be 500 nursing students?

MISS CRAWFORD: Yes.

THE CHAIRMAN: Have you given any consideration to the size of a building that would be required?

MISS CRAWFORD: Yes, this has been thought about -- the implications have been thought about.

THE CHAIRMAN: In terms of the medical school and University hospital, how many medical students are being graduated a year?

MISS CRAWFORD: 40, approximately.

THE CHAIRMAN: So they have, say, 160 students in the University in any one year?

MISS CRAWFORD: Yes.

THE CHAIRMAN: What you are asking for is a school that has three times the concept of the present medical school in Saskatoon? It is not an unambitious programme.

MISS CRAWFORD: The University does have in it three academic years of approximately 150 now.

THE CHAIRMAN: That is on a three-year --

MISS CRAWFORD: Well, the course is presently



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4 five years, and two years of the course are taken at the
University hospital.

5 THE CHAIRMAN: That is the clinical period?

6 MISS CRAWFORD: Yes.

7 THE CHAIRMAN: That is the (a) part of the
8 recommendation; the (b) part, two-year independent pro-
9 grammes leading to a diploma in nursing. Is that the
10 diploma that is intended to qualify a nurse for her R.N.?

11 MISS CRAWFORD: Yes, that is.

12 THE CHAIRMAN: And that would replace the
present three-year programme?

13 MISS CRAWFORD: Yes.

14 THE CHAIRMAN: In mentioning the two-year
15 period do you include in that two-year period the present
16 six months allocation of time with the Centralized Teach-
17 ing Programme?

18 MISS CRAWFORD: The present allocation of time
19 under C.T.P. is four months, and a revision in the role
20 of the C.T.P. is anticipated. This is a project of the
21 Centralized Teaching Programme, but they are studying a
revision now.

22 THE CHAIRMAN: Is this two years additional
23 to that?

24 MISS CRAWFORD: No, it would be inclusive.

25 COMMISSIONER McCUTCHEON: This would be like
26 the Windsor plan?

27 MISS CRAWFORD: Similar to the Windsor plan.

28 THE CHAIRMAN: Where would this instruction
take place?

29 MISS CRAWFORD: In Saskatoon.
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THE CHAIRMAN: What kind of institution?

MISS CRAWFORD: In a separate institution built for the school, or made available for this school.

THE CHAIRMAN: What enrollment would you expect?

MISS CRAWFORD: Well, we have suggested ultimately 500 graduating a year.

THE CHAIRMAN: That would be 1,000 in the school?

MISS CRAWFORD: When four schools are operating it was anticipated each school may have about 200 to 250.

THE CHAIRMAN: That is 125 a year?

MISS CRAWFORD: Yes.

THE CHAIRMAN: 125 going in every year, and 125 out every year?

MISS CRAWFORD: Yes.

THE CHAIRMAN: How many nurses are now being graduated leading to their R.N. qualification each year in Saskatchewan?

MISS CRAWFORD: Around 450 a year; it varies from year to year, but this is an average.

THE CHAIRMAN: Is this a programme where the students would pay tuition?

MISS CRAWFORD: The proposed two-year programme?

THE CHAIRMAN: Yes.

MISS CRAWFORD: We hadn't come to a definite conclusion about this, but it was thought they should pay tuition.

THE CHAIRMAN: And maintenance?

MISS CRAWFORD: Again, it was thought this



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4 might be offered in stages. Since nurses have not been
5 accustomed to paying for their education either in terms
6 of tuition or maintenance, our feeling was it may be
7 necessary to gradually build up acceptance of this idea,
8 and at first tuition may be required, and later both
9 tuition and maintenance.

10 THE CHAIRMAN: If maintenance was not required,
11 who would provide the maintenance?

12 MISS CRAWFORD: The first stage of this pro-
13 gramme, it was thought that it might be possible to have
14 eight months of this handled by the Centralized Teaching
15 Programme presently in existence, and sixteen months
16 handled by schools of nursing presently in existence, and
17 they might continue to pay for the second sixteen-month
18 period.

19 THE CHAIRMAN: That eight months that the
20 C.T.P. would take up would have to be charged someplace?

21 MISS CRAWFORD: Yes.

22 THE CHAIRMAN: The four months is now paid by
23 the Hospital Services Planning Commission through the
24 school?

25 MISS CRAWFORD: That is correct.

26 THE CHAIRMAN: So you would be asking the
27 Hospital Services Planning Commission to double its bud-
28 get in that respect?

29 MISS CRAWFORD: That is right.

30 THE CHAIRMAN: You are suggesting these schools
be independent schools; that is, detached from the
hospital?

MISS CRAWFORD: Yes.



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4 THE CHAIRMAN: I am not talking in terms of
5 feet or yards, but how far removed in the sense of being
6 removed from control?

7 MISS CRAWFORD: This is a new idea, a new
8 concept: there are not many schools in this Country that
9 are independent, and so we have envisaged several ways
10 this may be done, that the school may be set up as a
11 completely independent separate school in a similar man-
12 ner to the four months course offered by the Centralized
13 Teaching Programme, or the hospital endow or set up a
14 separate school, but it would have its own board of
15 management, its own principal of the school, and it would
16 have a separate budget administered by itself, or that the
17 hospital in some way -- these were possibilities we have
18 considered. We don't have any firm ideas on this.

19 THE CHAIRMAN: You would double the C.T.P.
20 period to eight months?

21 MISS CRAWFORD: Yes.

22 THE CHAIRMAN: You would shorten the whole
23 course, including this eight months, to two years?

24 MISS CRAWFORD: Yes.

25 THE CHAIRMAN: So that any clinical instruction
26 would come in the sixteen-month period?

27 MISS CRAWFORD: The C.T.P. period would in-
28 clude some clinical instruction.

29 THE CHAIRMAN: In what form?

30 MISS CRAWFORD: In the form used again by
other independent schools, that the C.T.P. staff would
teach basic nursing courses and arrange for accommodation
in hospitals conveniently accessible to the centre.



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4 THE CHAIRMAN: Do you know any place where
5 that is done?

6 MISS CRAWFORD: Exactly in the way I have des-
7 cribed it?

8 THE CHAIRMAN: Yes.

9 MISS CRAWFORD: Well, the Nightingale School
10 in Toronto -- the entire two-year programme is operating
11 this way.

12 THE CHAIRMAN: How many students are there at
13 that school?

14 MISS CRAWFORD: I don't really know.

15 THE CHAIRMAN: Is it ten's or hundred's?

16 MISS CRAWFORD: It is somewhere in the ten's
17 -- 50 or 60 in a year.

18 CH/jc COMMISSIONER McCUTCHEON: That is a very recent
19 programme?

20 MISS CRAWFORD: Yes, this programme has not
21 yet graduated its first class, they will be graduating
22 this fall.

23 THE CHAIRMAN: And are tuition fees paid at
24 the Nightingale School?

25 MISS CRAWFORD: Yes, \$75. a year.

26 THE CHAIRMAN: Who is subsidizing that school?

27 MISS CRAWFORD: I understand the Ontario
28 Hospital Commission.

29 THE CHAIRMAN: Is it a pilot project?

30 MISS CRAWFORD: It is an experimental project.

COMMISSIONER McCUTCHEON: I can confirm that,
Mr. Chairman.

THE CHAIRMAN: Coming to the foot of page 6

THE CHAIRMAN: Do you know any place where

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Hospital Commission.

THE CHAIRMAN: Is it a pilot project?

COMMISSIONER MCGOWAN: I can confirm that,

THE CHAIRMAN: Coming to the foot of page 6



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4 in the first section of the recommendations, the second
5 paragraph, recommendation no. 18 we pick up the next
6 heading:

7 "The following conclusions and recommendations
8 pertain to terms of reference."

9 And you say:

10 "Since the S.R.N.A. proposes that nursing
11 students no longer subsidize the cost of nursing education
12 through their services, it is necessary to consider alter-
13 native methods of supplying staff to hospitals and of
14 financing nursing education."

15 Do you put that forward seriously?

16 MISS CRAWFORD: You mean do we mean this is
17 what they do now?

18 THE CHAIRMAN: Yes?

19 MISS CRAWFORD: We feel that is the way they
20 pay for their education.

21 THE CHAIRMAN: They pay for their education?

22 MISS CRAWFORD: The nursing student pays for
23 her education by working in the hospital and also for her
24 maintenance.

25 THE CHAIRMAN: And do you think that it could
26 be done more economically by her paying tuition and maint-
27 enance?

28 MISS CRAWFORD: It could be done on a more
29 sound basis. At the present nobody really knows whether
30 the student is giving more than she is receiving or re-
ceiving more than she is giving. We do know that --

THE CHAIRMAN: Well, studies have been made,
have they not?



MISS CRAWFORD: Whether the student is giving or receiving?

THE CHAIRMAN: Yes, as to whether it is costing the hospital more to operate a nursing school with the economic value of nursing school to the hospital.

MISS CRAWFORD: One study was made in this Province but the data was collected in 1953.

THE CHAIRMAN: It was available about 1954 or 1955, was it not?

MISS CRAWFORD: Schools of nursing have changed quite a bit even since then. We are not sure how much of that is still valid.

THE CHAIRMAN: That was before the Centralized Teaching Programme came in, was it not?

MISS CRAWFORD: Yes.

THE CHAIRMAN: So that any change would be that a nurse was working in the hospital four months more at that time than she is now?

MISS CRAWFORD: But the costs from different schools reporting, different hospitals reporting in the study were quite variable, the range of costs.

THE CHAIRMAN: Have you had access to the survey that was made by the Kellogg people in Michigan?

MISS CRAWFORD: No.

THE CHAIRMAN: Perhaps Miss Girard may wish to deal with that. You have a sort of self-deprecating statement on page 7:

"It is obvious that present methods are not producing well qualified nurses who are highly competent in the planning and implementation of



on working

THE HANOVER: Yes, as I mentioned it is costing the hospital more to operate a nursing school with the economic value of a nursing school to the hospital.
MISS GRAYSON: The study was made in this connection but the data was collected in 1955.

MISS GRAYSON: Hospitals that have remained have changed quite a bit since then. We are not sure how much of that is still valid.

THE HANOVER: Yes, was it not?
MISS GRAYSON: Yes.

THE HANOVER: Is that any change would be that it was not in the hospital four months more at that time when it was not?

MISS GRAYSON: But the cost from different no more was not, of course, hospital working in the same range of costs.

THE HANOVER: Have you had access to the survey that was made in the other people in Minnesota?

THE HANOVER: Perhaps a word may wish to deal with that. You have a sort of self-deception statement on page 1.

"It is obvious that present methods are not working well qualified nurses who are right, competent in the planning and implementation of



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4 patient care who can guide and teach others."

5 Is it not a fact that the Canadian trained
6 nurse can get a job any place in the world because of her
7 qualifications?

8 MISS CRAWFORD: Yes, a Canadian trained nurse
9 is able to go to many other Countries.

10 THE CHAIRMAN: They are regarded as amongst
11 the best qualified nurses in the nursing profession in
12 the world, are they not?

13 MISS CRAWFORD: I do not know whether this is
14 so. They do not seem to have any difficulty in receiving
15 appointments in any other Country.

16 THE CHAIRMAN: You know they are highly wel-
17 comed below the line?

18 MISS CRAWFORD: Yes, they are in the United
19 States, the Canadian nurses have no difficulty in finding
20 jobs.

21 THE CHAIRMAN: And in finding supervisory jobs,
22 that is right, is it not?

23 MISS HIBBERT: Some of them.

24 MISS CRAWFORD: I think it would be more dif-
25 ficult than here.

26 THE CHAIRMAN: Well, there are more good ones
27 to pick from there. Now, recommendation no. 25:

28 "That the employing agencies be encouraged
29 and enabled to remunerate nurses in positions of
30 responsibility in a manner comensurate with their
preparation and the responsibility inherent in the
position."

Do you mean by that that the hospital



administration should be encouraged to increase the wage level?

MISS CRAWFORD: No, not the wage level but the differential for different kinds of positions and for nurses' added preparation.

THE CHAIRMAN: You would not lower anybody so you are going to make a differentiation upwards?

MISS CRAWFORD: Yes, that is right.

COMMISSIONER McCUTCHEON: You ought to pay the specialist more.

MISS CRAWFORD: Specialist?

COMMISSIONER McCUTCHEON: I have been sitting with medical men so long --

THE CHAIRMAN: Well, those who have taken some form of post-graduate training and that kind of thing?

MISS CRAWFORD: That is right.

THE CHAIRMAN: Naturally they would increase the hospital budget?

MISS CRAWFORD: Yes.

THE CHAIRMAN: And naturally that would bring the hospital into discussion with the rate board of the Hospital Services Planning Commission?

MISS CRAWFORD: It is a factor not only in the hospital situation but in the public health field as well.

THE CHAIRMAN: I was wondering if that is the kind of thing you had in mind.

MISS CRAWFORD: Yes, it is.

THE CHAIRMAN: That is the sort of procedure that has to be gone through before that type of



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4 recommendation can be made effective. You appreciate
5 that the hospital itself cannot increase the wages unless
6 its budget is also increased?

7 MISS CRAWFORD: This was the reason for making
8 our recommendation.

9 COMMISSIONER GIRARD: Mr. Chairman, I have a
10 few questions but I think I will start with the subject
11 that you were just speaking of now and instead of 25 if
12 we went up to 24 because I think that is a very important
13 one. In the question of salaries the one that says that
14 salary ranges for nurses providing direct patient care
15 be so constructed as to permit greater increases, financial
16 recognition, for additional preparation and for quality
17 service in the clinical areas.

18 Would one of you like to elaborate on that.
19 I think we all have particular ideas about this parti-
20 cular person and what she should get through remuneration
21 and what we would expect from her if her remuneration was
22 dealt with in a better manner.

23 MISS CRAWFORD: I would like to start. The
24 present structure of salaries really only allows the nurse
25 to move to a better salaried position if she moves away
26 from the patient care to the role of head nurse or super-
27 visor or to the role of teaching. There is no provision
28 to recognize that nurses giving bedside care over a period
29 of years have developed many abilities which should be
30 receiving much higher salary.

31 COMMISSIONER GIRARD: We know the criticism
32 that our good bedside nurses are not staying in bedside
33 care.



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MISS CRAWFORD: That is right.

COMMISSIONER GIRARD: But this is one of the reasons we cannot keep our nurses in bedside care, because in order to give them some recognition they have to move out, otherwise their salary is not comensurate with the treatment they are giving so we move them to head nurses or into the school. This is a vicious circle and we find we have not the right kind of nurse for bedside care.

MISS CRAWFORD: That is exactly right.

COMMISSIONER BALTZAN: Is there not an escalator clause for a nurse who has been one year or two years in a hospital? There is an increment?

MISS CRAWFORD: There is an increment but it ends very quickly, four or five increments and then it stops as a rule.

COMMISSIONER McCUTCHEON: Three percent provides a very big increment.

COMMISSIONER VAN WART: Nurses' assistants, are they taking over the bedside care?

MISS CRAWFORD: Yes, they are.

COMMISSIONER VAN WART: Have you any difficulty in getting nursing assistants?

MISS CRAWFORD: There is still a shortage at the moment. There seems to be an increased interest in this kind of preparation and the courses are receiving more applicants every year.

COMMISSIONER VAN WART: Is the salary one of the reasons why there is a shortage of nurses' assistants?

MISS CRAWFORD: Salary is about 70 percent of the salary of a registered nurse in this Province and the



preparation at the moment is ten and a half months as compared to three years.

THE CHAIRMAN: Are the educational qualifications the same?

MISS CRAWFORD: No. The minimal educational qualification is grade IX standing; minimal educational qualification for a nurse entering the training at the moment is grade XI and in two years this will be grade XII.

COMMISSIONER VAN WART: There you are recommending twelve months training for nurses' assistants?

MISS CRAWFORD: We are not recommending this, this has already been recommended and approved about two years ago so we are recommending that it go no further than this.

COMMISSIONER VAN WART: Is it in effect now?

MISS CRAWFORD: It has been held up because the Canadian Vocational Training School is building and they do not intend to increase their curriculum until their building is finished.

COMMISSIONER VAN WART: In other words, when they get their building facilities they will be able to turn out more nursing assistants. Is the nurses' assistant's salary on a graded scale or does she remain at the same salary?

MISS CRAWFORD: Hers is graded in a similar manner, four or five increments and then it stops in most places.

COMMISSIONER VAN WART: You say 70 percent, that is 70 percent of what a registered nurse would get



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4 for doing the same duty?

5 MISS CRAWFORD: Oh no, not for doing the same
6 duties.

7 COMMISSIONER VAN WART: What do you mean by
8 your bedside -- nurses are leaving bedside nursing care
9 to take other supervisory positions and so on and the
10 vacuum is being filled by nurses' assistants; is that not
11 the same work?

12 MISS CRAWFORD: Only part of the same work.
13 Some of the vacuum has not been completely filled.

14 COMMISSIONER VAN WART: Such as what?

15 MISS CRAWFORD: The rehabilitation and teach-
16 ing aspects of the care the nurses give. This is not for
17 the most part, done by the nursing assistants if they
18 are the person giving the care.

19 COMMISSIONER VAN WART: Nursing assistants
20 give no teaching instruction at all?

21 MISS CRAWFORD: In terms of their educational
22 qualifications before they enter the course and the quali-
23 fications after they are not prepared too.

24 COMMISSIONER VAN WART: They do not instruct
25 nursing assistants, that is all done by registered nurses?

26 MISS CRAWFORD: Yes.

27 COMMISSIONER GIRARD: Miss Crawford, on page
28 55, appendix IX, there is a comparison of achievement of
29 Saskatchewan students with students of 54 jurisdictions
30 on state board test pool examinations from September 1959
and September 1960. The mean score for Saskatchewan
students on these pools in comparison with the 54 other
jurisdictions are all below the national means score.



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4 for doing the same duty?

5 MISS CRAWFORD: Oh no, not for doing the same
6 duties.

7 COMMISSIONER VAN WART: What do you mean by
8 your bedside -- nurses are leaving bedside nursing care
9 to take other supervisory positions and so on and the
10 vacuum is being filled by nurses' assistants; is that not
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30 on state board test pool examinations from September 1959
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students on these pools in comparison with the 54 other
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MISS CRAWFORD: This has been giving us a great deal of concern and we are not sure why. As the chairman indicated earlier, this is one of the reasons that we were bold enough to include the statement that our present programmes were not preparing nurses as competent as they should be. We have some theories, we feel that perhaps some of the smaller schools do not have sufficient facilities to provide an adequate programme and we have a number of small schools. We wonder if the fact we have not been able to arrange for experience in psychiatric clinics for about 50 percent of our students is a factor in any way.

COMMISSIONER GIRARD: You mean 50 percent of the students do not have psychiatric experience?

MISS CRAWFORD: That is right.

COMMISSIONER GIRARD: Therefore, in that subject they must be low.

MISS CRAWFORD: Another factor may be lack of proper instructors. There is still a very small percentage of instructors with a bachelor's degree in our schools of nursing and many of them have a one-year preparation but nothing beyond this.

COMMISSIONER GIRARD: Do you have any idea how your University students compare in these tests?

MISS CRAWFORD: Yes, I happen to know this since I am associated with the University school. They are higher than the other schools.

COMMISSIONER GIRARD: Higher than the national mean?

MISS CRAWFORD: Yes, higher than the national



MISS OKUBO: I think so -- I believe that is

COMMISSIONER CHANDLER: So then you are a member

of the National Association of State Boards of Education in

the University of Chicago and the University of

Miss Okubo: Yes, there is a member

THE CHAIRMAN: There is a member and one is

a five-year member.

MISS OKUBO: I am a five-year member and one is

down. The five-year member is the highest and the

three-year member is the next highest.

COMMISSIONER CHANDLER: The highest for the

five-year member is the highest and the three-year

MISS OKUBO: I think that larger schools, there

are more in the way of the larger schools.

MISS OKUBO: I am not sure about that but I am not

sure. And there are in the way of the larger

schools, in the way.

COMMISSIONER CHANDLER: This would bring down

THE CHAIRMAN: But in number what is your pro-

positional number governing each year from the larger

schools in terms of your five larger schools and your

smaller ones, as you call them? Are there any



mean.

COMMISSIONER GIRARD: On all scores?

MISS CRAWFORD: I think so -- I believe that is right.

COMMISSIONER GIRARD: So then you see a marked difference in the achievement tests of the students in the University course and the diploma school.

MISS CRAWFORD: Yes, there is a marked difference.

THE CHAIRMAN: One is a three-year and one is a five-year course.

MISS CRAWFORD: Students from both right straight down; the five-year course are the highest and the three-year course are the next highest.

COMMISSIONER GIRARD: The students from the five-year course are higher and the students from the three-year course -- ?

MISS CRAWFORD: Yes.

MISS McGRATH: I think our larger schools, their average is about the national mean. The larger schools we are not too concerned about but it is the smaller schools and those are in the majority; of our eleven schools, six are small.

COMMISSIONER GIRARD: This would bring down your --

MISS McGRATH: Yes.

THE CHAIRMAN: But in numbers what is your proportionate numbers graduating each year from the larger schools in terms of your five larger schools and your six smaller ones, as you call them? How many students are



MEMORANDUM FOR THE SECRETARY

DATE: 10/10/50. I think it is I believe that is

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the different courses and the diploma school.

MR. CRAWFORD: Yes, there is a marked

MR. HARRIS: There is a three-year and one is

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THE CHAIRMAN: But in terms what is your pro-

portionate number graduating each year from the larger

schools in terms of your five largest schools and your six

smaller ones, as you call them? How many students are



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3 in the six smaller ones?

4 MISS CRAWFORD: Less than half.

5 THE CHAIRMAN: There is bound to be less than
6 half. Well, you have it here someplace, between the
7 University hospital and the two large hospitals in Regina
8 and Saskatoon, the five schools would graduate 300 to
9 350 nurses a year, would they not?

10 MISS McGRATH: Oh no, because our total regis-
11 tration alone, about 395 to 420 and that is for the whole
12 Province.

13 THE CHAIRMAN: Don't they average about 60 to
14 pass the graduation, the four anyway, that is 240, and
15 how many does the University graduate?

16 MISS CRAWFORD: 50.

17 THE CHAIRMAN: That would be 290. I mean, I
18 don't want to be controversial about it, but I suppose
19 we want the facts, rather than --

20 MISS CRAWFORD: There would be about 290 to
21 325 in the larger schools.

22 THE CHAIRMAN: And about 60 or so from all the
23 rest?

24 MISS CRAWFORD: No, no, our figure was 450.

25 THE CHAIRMAN: About 160?

26 MISS CRAWFORD: A hundred or so, at least a
27 hundred.

28 COMMISSIONER GIRARD: Miss Crawford, about the
29 Central Training Programme which has gotten wide pub-
30 licity. I believe there were advantages and some dis-
advantages to the Central Training Programme as it has
been carried on, not the one that you would advocate in



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4 the plan here, but the one as it was carried on. Could
5 you tell us what were the advantages and the disadvantages,
6 if there were any?

7 MISS CRAWFORD: The advantages, this was able
8 to give a high level of instruction. The nursing in-
9 structors employed were, and are, prepared, and instruct-
10 ors have been used from the University and associated
11 colleges, and from the University in Regina, so that the
12 curriculum and the instruction have been an improvement
13 over that which some of the small schools could give.

14 Some of the disadvantages, this is a course
15 given in four months, which is barely enough time for the
16 student to adjust to a very new kind of subject matter,
17 and to do this away from her home setting, and a great
18 deal of tension has been generated throughout this course.

19 It does separate principles artificially, some
20 of the basic science subjects, and some of the nursing
21 practices, and this is thought to be a disadvantage.

22 COMMISSIONER GIRARD: How about the follow-up
23 of those students from the Central Training point to the
24 mother hospital, or their home hospital?

25 MISS CRAWFORD: This was proposed as one of
26 the things the Central Teaching Programme should do, but
27 due to a variety of factors has not actually done very
28 effectively.

29 THE CHAIRMAN: Didn't Miss Keeler go about to
30 the various schools for a time?

MISS CRAWFORD: Mrs. Keeler was advisor to
three schools of nursing. This is a different role.

THE CHAIRMAN: Yes, but she also had a role in



the plan here, but the one as it was carried on. Could
you tell us what were the advantages and the disadvantages
if there were any?

MISS GAWTHORP: The disadvantage, this was this
to give a high level of instruction. The nursing in-
struction employed were, and are, practical, and character-
istic have been used now the time they had associated
colleges, and from the beginning of training, so that the
character and the instruction in the school an improvement
over that which some of the other schools could give.
Some of the disadvantages, there is a certain
given in the matter, which is more a matter of time for the
student to adjust to a very high level of instruction. Then,
and to the fact that the instruction is more, and a greater
level of instruction has been given, and about this course
it does require a high level of instruction, and

of the level of instruction, and the level of the nursing
practice, and this is the reason for a disadvantage.
The disadvantage is that the level of the instruction
of these students is more than the level of the training
received, which, on the whole, is a disadvantage.
This, however, is the reason for the disadvantage, and

the things are the same for the time being, and should be
one to a certain level, and the level of the training

the level of the training is the same for the time being, and should be
one to a certain level, and the level of the training

the level of the training is the same for the time being, and should be
one to a certain level, and the level of the training



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4 C.T.P.?

5 MISS CRAWFORD: Yes, but she didn't go about
6 visiting the schools.

7 THE CHAIRMAN: You mean she changed her hat when
8 she was there?

9 MISS CRAWFORD: That is right, the C.T.P. did
10 have a travelling instructor for one or two sessions.

11 THE CHAIRMAN: I think at least two, if not
12 three.

13 MISS CRAWFORD: This was several years ago.
14 This was discontinued in recent times.

15 THE CHAIRMAN: Well, I haven't been a director
16 since 1957.

17 COMMISSIONER GIRARD: And how is the C.T.P.
18 functioning? I understand you are having only one en-
19 trance a year. Does that improve the programme?

20 MISS CRAWFORD: One by one the schools of
21 nursing in the Province have made the decision to, because
22 only one class a year, this caused a crisis in the C.T.P.,
23 because it is not possible economically to plan a formal
24 course and then have nothing to do for the rest of the
25 year.

26 COMMISSIONER GIRARD: For the instructors?

27 MISS CRAWFORD: For the school itself and the
28 instructors, and this is one of the reasons why the C.T.P.
29 has been looking after a revision of its programme.

30 COMMISSIONER VAN WART: On page 2 of your sum-
mary, it reads: "Since the demand for nursing care
continues to exceed the supply,". Is that demand general,
or is it in special, more in special agencies and so on?



MISS CRAWFORD: We feel that this is general.

COMMISSIONER VAN WART: And you go on to state that: "shortage of personnel may be intensified in certain agencies." What agencies are those? I think psychiatric nurses have been mentioned, and what other agencies are you short in?

MISS CRAWFORD: The very small hospitals, in small communities and rural communities have more difficulty in obtaining staff than hospitals in the large centres.

COMMISSIONER VAN WART: That is nursing assistants, as well as registered nurses?

MISS CRAWFORD: Yes, all kinds of staff.

COMMISSIONER VAN WART: Is there any reason for that?

MISS CRAWFORD: We don't know. We have again some theories that most of the members of the profession, and also the nursing assistants, seem to prefer the larger communities.

COMMISSIONER VAN WART: Have you any solution to get nurses to go into the smaller hospitals? Have you studied that aspect of it?

MISS CRAWFORD: One solution that some of the smaller hospitals have tried is to offer considerably larger salaries, and this has been in some ways effective. We have suggested that some of these smaller hospitals might be looked at very closely, and their value, and their economic value in the community be questioned, and they might perhaps be closed.

THE CHAIRMAN: How many such hospitals do you



1035 (RAW) 1035: We feel that this is a general.

COMMISSIONER V.W. 1035: We feel that this is a general.

that: either in personnel, or in facilities, in certain
agencies, but especially in the case of the psychiatric
hospitals, and what I am saying is that the agencies are

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4 think exist in Saskatchewan?

5 MISS McGRATH: Well, there are approximately
6 between 92 and 96 hospitals of 25 beds and less.

7 THE CHAIRMAN: Scattered all over the place?

8 MISS McGRATH: All over the Province, yes.

9 MISS CRAWFORD: Mostly in the southern half.

10 THE CHAIRMAN: The settled half.

11 COMMISSIONER VAN WART: You would not need
12 numbers of highly trained nurses in those hospitals like
13 a big general hospital with more acutely ill patients,
14 and nurses' assistants could carry on with proper super-
15 vision in this?

16 MISS McGRATH: No, this is not true, because
17 the admissions are not restricted. The type of patients
18 admitted are not restricted in the smaller hospital, and
19 you get your acutely ill patient there.

20 COMMISSIONER VAN WART: But many of them we
21 have found out that the utilization was only 65 percent
22 in one, as compared with 90 percent in the larger hospi-
23 tals, and one of the reasons given was that the acutely
24 ill were transferred from these hospitals to the larger
25 general hospitals.

26 MISS McGRATH: Yes, but even if you only have
27 one patient in the smaller institution, and the patient
28 need not be acutely ill, and we have to provide profes-
29 sional coverage on a 24-hour basis, and this cannot be
30 done adequately on a rotating basis and an eight-hour
shift, and providing for annual and statutory holidays,
with less than 5 people, because you cannot take a
chance.



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4 COMMISSIONER VAN WART: Is it financial, or is
5 it shortage of availability of staff?

6 MISS McGRATH: It is shortage of availability
7 of staff, and these vary, and there are a great number of
8 them. There is nothing to attract or induce a person to
9 stay except there is a differential in salary, but this
10 does not seem to compensate for the niceties in life that
11 they have to do without. So many of our nurses have gone
12 from rural areas, from unmodern homes, and they have been
13 accustomed to two or three years of nice living, and they
14 have improved the situation, and they do not want to go
15 back.

16 COMMISSIONER VAN WART: Following that up, on -
17 page 7, no. 21, you say: "That bursaries and loan funds
18 be extended." Are there any conditions attached to your
19 bursaries? If so, what are they?

20 MISS CRAWFORD: Do you mean the bursaries that
21 are presently offered?

22 COMMISSIONER VAN WART: Well, what you are ad-
23 vocating, or what is in effect. It is: "Bursaries and
24 loan funds be extended." That means presently in effect.

25 MISS CRAWFORD: Yes, the bursaries that are
26 available at the moment, there are not bursaries avail-
27 able to undergraduates, to students taking a basic
28 programme. There are loan funds available, and these
29 must be repaid. The applicant has six months after the
30 completion of her course before repayment is necessary,
and they are interest-free.

Bursaries are available to graduate nurses
wishing to take post-graduate preparation, and these



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4 have the restriction of service, the commitment for
5 service. A graduate nurse must work for two years.

6 COMMISSIONER VAN WART: Have you given any consideration for
7 bursaries for nurses' assistants, to help fill the voids?

8 MISS CRAWFORD: The nursing assistants receive
9 considerable support through the vocational training pro-
10 gramme. They receive, I believe we have mentioned this
11 in the brief, they receive an allowance of approximately
12 \$60. per month during the three and a half months education-
13 al part of the course. Transportation is paid, and then
14 in the remaining seven months the student receives board,
15 room, laundry, uniforms, and an allowance of \$10. a month.

16 COMMISSIONER VAN WART: And what is the condition
17 attached to that?

18 MISS CRAWFORD: No condition.

19 COMMISSIONER VAN WART: She can turn out and
20 take a course for stenography the next day, and if she
21 graduates, she can go on with her stenography.

22 MISS CRAWFORD: Yes.

23 COMMISSIONER STRACHAN: Mr. Chairman, referring
24 back to recommendation no. 2, the second sentence, I
25 wonder if this sentence means what it states, or whether
26 I am misinterpreting it, but I think of the remark just
27 made a moment or so ago that these smaller hospitals must
28 have staff to render adequate service to acutely ill
29 patients, and yet in this sentence it says: " -- smaller
30 hospitals which cannot be adequately staffed to give
safe care should not admit acutely ill patients." If I
may express a personal feeling, I think if I were, it
all depends on the degree of acuteness of course, but if

have the restriction of service, the commitment for service. A graduate nurse must work for two years.

COMMISSIONER: I am not sure, but I think the Commission for Nurses, Assistant, to help fill the voids? MISS CALVERT: The nursing assistants receive

grants. They receive, I believe we have mentioned this in the past, they receive an allowance of approximately \$60. per month during the first and a last months education at part of the course. The education is paid, and then in the remaining seven months the student receives board, room, laundry, utilities, and an allowance of \$10. a month.

COMMISSIONER VAN WART: And what is the condition attached to that?

MISS CALVERT: No condition. COMMISSIONER VAN WART: And can you not and take a course for stenography one next day, and if she graduates, she can go to work for stenography.

COMMISSIONER TRACHMAN: Mr. Chairman, referring back to recommendation no. 2, the second sentence, I wonder if that sentence means what it states, or whether I am misinterpreting it, but I think of the remark just made a moment or so ago that these smaller hospitals must have staff to render adequate service to acutely ill patients, and yet in this sentence it says: " -- smaller hospitals which cannot be adequately staffed to give such care should not admit acutely ill patients." If I may express a personal feeling, I think if I were, it all depends on the degree of acuteness of course, but



I were acutely ill, it would seem to me that I would be glad to take any haven, rather than travel great distances. I wonder if you would explain this sentence?

MISS CRAWFORD: We are suggesting that if the hospital cannot give adequate nursing care, that it should not admit patients that need professional nursing care, and we feel that the patient might be better looked after in the home, or there is an air ambulance service in this Province which might be utilized. For many months of the year roads are open, and patients may be transported quite easily to a larger centre.

COMMISSIONER STRACHAN: I am thinking of the patient that needs attention right away. You just cannot afford that time element to go to any other place?

MISS McGRATH: Oh, well, this would be an emergency.

MISS CRAWFORD: Presumably if a patient needed this kind of emergency care and there was a facility close at hand, he would be admitted to it, but the Province is not yet covered with hospitals every two blocks.

MISS McGRATH: One of our concerns in this respect is that we cannot control the quality of our training programme, and we know that nursing assistants, and sometimes people without any preparation, are required to give care that they should not be giving. They haven't any right to be giving this care. We can set minimum standards, but not the functions that they do.

COMMISSIONER STRACHAN: One other thing, Mr. Chairman, and I have little enthusiasm to continue this long day, but I find it extremely difficult to understand



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4 why the nursing organizations and associations should be
5 recommending this entire change of nurse training, without
6 being able to quote from some pilot study which has been
7 made, or some past experience. It seems to me that these
8 recommendations are enthusiastically put forth of some-
9 thing which has not yet been proven. How has this idea
10 caught fire? Someone must have gone across the Dominion,
11 or around this North American continent, with a good
12 sales talk on this idea?

12 MISS CRAWFORD: There are demonstrations and
13 pilot projects. Someone mentioned earlier the Metro-
14 politan School of Nursing at Windsor, Ontario, which
15 operated for four years. We are looking with interest
16 at the programme at the Nightingale School of Nursing
17 in Toronto. The University schools at New Brunswick,
18 British Columbia, and McGill University are offering a
19 different kind of degree programme than we have seen in
20 this Country. In the United States there are many re-
21 ports of two-year programmes that have been offered in
22 a number of community and junior colleges across the
23 Country.

24 These are the kind of things we have been
25 looking at. They are all different. There are some
26 principles common to them all, and we would like to ap-
27 ply these common principles, and try out the different
28 factors involved.

29 COMMISSIONER STRACHAN: How many years' prod-
30 ucts from these institutions have been realized?

MISS CRAWFORD: The Metropolitan School ex-
isted between 1948 and 1952, and then discontinued. The



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could take in the field

and the nursing organizations and

politan school of nursing at Windsor, Ontario, which operated for four years. We are working with interest in the movement of the nursing school of Windsor in Ontario. The University School of New Brunswick, in New Brunswick, a small university are offering a different kind of degree program than we have seen in this country. In the United States there are many re- ports of two-year programs that have been offered in a number of community and nursing colleges across the

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ply these to our programs, and try out the different

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WINDSOR, ONTARIO, ST. ANNE'S - now many years' pro-

with from these institutions we have been realizing

MISS GORDON: The New School of Nursing ex-



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4 United States' programmes have been in existence since
5 1953, and they have some 60 programmes now, with gradu-
6 ates from each of these.

7 COMMISSIONER STRACHAN: Are they all producing
8 better nurses?

9 MISS CRAWFORD: The American nurses feel this.

10 COMMISSIONER GIRARD: Miss Crawford, could we
11 not say also that the Lord Report gave us some idea of
12 the quality of the nurses produced at the Windsor School?
13 We had a controlled experimental school with a report
14 by an independent, not a nurse, by an independent person,
15 and the report is published on the value of such a school.

16 COMMISSIONER STRACHAN: Was it said that it was
17 discontinued?

18 COMMISSIONER GIRARD: We didn't have the money.
19 It was only an experimental programme set for a certain
20 length of time.

21 COMMISSIONER McCUTCHEON: It was financed by
22 an Ontario foundation, was it not?

23 COMMISSIONER GIRARD: By Red Cross and Ontario
24 money, not an Ontario foundation. Some money was lack-
25 ing for the last year, and that was brought in by maybe
26 the foundation, but the first part was by Red Cross.

27 COMMISSIONER STRACHAN: It would seem reason-
28 able to conclude that if it was found to be a success
29 that money could be found to continue such an operation?

30 COMMISSIONER GIRARD: Well, that is what we
are trying to get at.

MISS CRAWFORD: We are rather mystified our-
selves as to why, when it is so obvious that this has



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 ...and they have some 60 programs now, with grad-
 ates from each of these.
 COMMISSIONER ALBACH: Are they all producing
 better nurses?

MRS. CRAWFORD: The American nurses feel this.
 ...
 not say after they had spent some time in
 the quality of the work done in the Wisconsin School?
 We had a comparative exam-... school with a report
 by an independent, not a nurse, by an independent person,
 and the report is published in the volume of such a school
 COMMISSIONER ALBACH: It is said that it was
 discredited.

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 length of time.
 COMMISSIONER ALBACH: It was financed by
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COMMISSIONER GIBBY: By Red Cross and Ontario
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 MRS. CRAWFORD: We are rather mystified our-
 selves as to why, when it is so obvious that this has



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4 been such a good programme, it has been so difficult to
5 get more programmes under way.

6 COMMISSIONER GIRARD: Mr. Chairman, I have one
7 more question. I don't know, Miss Crawford, whether you
8 were in the room today, or whether it was yesterday, I
9 am a bit confused by now. Reference was made to the --
10 what we call the old league of nursing norms of the 3.4
11 and 3.5 hours of nursing. I see that on the page marked
12 summary and recommendations, recommendation no. 1 says:
13 "That the Royal Commission on Health Services for Canada
14 support a study to determine the quantity and quality of
15 nursing care required by patients with different medical
16 and dependency needs and in varying situations, -- "
17 and so on and so forth. Is your idea of this study some-
18 thing that would give us more up to date and more ap-
19 propriate figures, in order to determine norms that we
20 will need so badly in the future years, to be able to
21 comply with hospital regulations?

je 22 MISS CRAWFORD: Yes, that is our reason for
23 making this recommendation. The norms that were published
24 in 1950 were even then not felt to be accurate, and they
25 published them and almost immediately sent out a state-
26 ment these should be used with caution, and yet somehow
27 or other they seemed to have been built into most of our
28 planning and budgetary systems.

29 MISS HIBBERT: We are greatly in need of some
30 standard to help us decide how many staff we need for
what type of a situation, and we have nothing to lean on
at the moment. We feel that there is great need to study
this, and it is suggested we start looking at what the



been such a good programme, it has been so difficult to
get more programmes under way.
COMMISSIONER CLARK: A. Chairman, I have one
more question. I don't know, Miss Crawford, whether you
were in the room today, or whether it was yesterday, I
am a bit confused by now. Reference was made to the
what we call the old lease of nursing homes of the 19th
and 20th century of nursing. I see that in the case marked
summary and income tax, recommendation no. 1 says,
"That the Royal Commission on Health Services for Canada
support a study to determine the quantity and quality of
nursing care required by patients with different medical
and dependency needs and in varying situations, --"
and so on and so forth. Is your idea of this study some-
thing that would give us more up to date and more ac-
curate figures, in order to determine norms that we
will need to abide in the future years, to be able to
comply with hospital regulations?
MISS CRAWFORD: Yes, that is our reason for
making this recommendation. The norms that were published
in 1950 were even then felt to be accurate, and they
published them and almost immediately sent out a state-
ment that these should be used with caution, and yet somehow
on other they seemed to have been built into most of our
planning and industry systems.
MISS BRIGHT: We are greatly in need of some
standard to help us decide how many staff we need for
what type of a situation, and we have nothing to lean on
at the moment. We feel that there is great need to study
this, and it is suggested we start looking at what the



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4 patient needs for nursing care in the current situation,
5 and we have nothing to lean on but tradition.

6 THE CHAIRMAN: The rate card has picked on the
7 figure of 3.4.

8 MISS HIBBERT: Yes, and this is unfortunate.

9 THE CHAIRMAN: You don't think it is adequate?

10 MISS HIBBERT: We can't say it is adequate for
11 all situations, they are so different from one hospital
12 to another, and from one unit to another in a hospital.

13 THE CHAIRMAN: When that is used as a basis
14 for computing the amount of money allowed for nursing
15 services in a hospital budget, it may be quite unreal-
16 istic?

17 MISS HIBBERT: Quite.

18 THE CHAIRMAN: You say this was a figure which
19 came out in 1950?

20 MISS HIBBERT: Yes.

21 THE CHAIRMAN: And it was more or less simul-
22 taneously challenged at the time?

23 MISS HIBBERT: It said at the time you should
24 study your own situation and decide how many hours you
25 need, and yet, at the same time, for surgery it stated
26 3.4 and for obstetrics something else, and hospitals
27 have latched on to this and use these figures in spite
28 of the fact that in one case they may include the head
29 nurse, but not in another.

30 THE CHAIRMAN: You say "latched on": you mean
the Hospital Services Planning Commission, or the
hospitals?

MISS HIBBERT: Probably both.

patient needs the nursing care in the current situation, and we have nothing to learn on the situation.

THE CHAIRMAN: The question has been placed on the

MISS HIBBERT: Yes, and this is unfortunate.

THE CHAIRMAN: You don't think it is adequate?

MISS HIBBERT: We don't know if it is adequate for

all situations, especially for the kind of work from one hospital

to another, or from one hospital to another in a hospital.

THE CHAIRMAN: You would regard it as a basis

for comparing the situation of other hospitals to your

service in a hospital, or for the way we compare ourselves

with

MISS HIBBERT: Certainly.

THE CHAIRMAN: You say there was a figure which

came out in 1950?

THE CHAIRMAN: And it was more or less similar-

the figure was similar to the figure

MISS HIBBERT: It said at the time you should

study your own situation and decide how many hours you

need, and yet, at the same time, too many, it stated

and for statistics something else, and hospitals

are looked on to this and use these figures in spite

of the fact that in one case they may include the board

nurse, but not in another.

THE CHAIRMAN: You say "looked on": you mean

the Hospital Services Planning Commission, or the

hospital?

MISS HIBBERT: Probably both.



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3 THE CHAIRMAN: Do you not know it is the
4 Hospital Services Planning Commission that sets the
5 standard -- sets the amount of money a hospital can spend
6 in a given year for nursing services?

7 MISS HIBBERT: It helps hospitals decide.

8 MISS CRAWFORD: I think too when Miss Hibbert
9 said hospitals and Hospital Services Planning Commission
10 she was not only referring to this Province, but hospitals
11 generally. In this Province the Commission does set the
12 figure.

13 COMMISSIONER GIRARD: You could say that
14 directors of nursing are also responsible for this sort
15 of affairs -- that they have used these norms for want
16 of a better one, and this was an American yardstick. It
17 never was made on our own basis of Canadian nursing, but
18 we used it, and I am guilty of it too. We have used it
19 because we have had nothing else, and we are probably
20 the ones who turned it over to the hospital authorities.

21 THE CHAIRMAN: It is an awful sin to have on
22 your soul, Miss Girard.

23 COMMISSIONER GIRARD: Wouldn't you also say
24 that so many things have changed since then, since 1950?
25 The kind of nursing care we give now, for instance --
26 neuro-surgery in certain instances on some reports that
27 have been published require eleven hours of nursing
28 service per patient, and cardiology requires eight, nine
29 and ten hours. So, this is just to show how unrealistic
30 those figures are, and I think we should stop using
them or try to get some new tools to measure what we
want to measure.



THE CHAIRMAN: Do you not know it is the
Hospital Services Planning Commission that sets the
standard -- sets the amount of money a hospital can spend
in a given year for nursing services?

MISS HIBBERT: It helps hospitals decide.

MISS CRAWFORD: I think too when Miss Hibbert
said hospitals and Hospital Services Planning Commission
she was not only referring to this province, but hospital
generally. In this Province the Commission does set the

directors of nursing are also responsible for this sort
of affairs -- that they have used these norms for want
of a better one, and this was an American yardstick. It
never was made on our own basis of Canadian nursing, but
we used it, and I am guilty of it too. We have used it
because we have had nothing else, and we are probably
the ones who turned it over to the hospital authorities.

THE CHAIRMAN: It is a awful sin to have on

your soul, Miss Hibbert.

COMMISSIONER OF HEALTH: Wouldn't you also say

that so many things have changed since then, since 1950?
The kind of nursing care we give now, for instance --
neuro-surgery in certain instances on some reports that
have been published require eleven hours of nursing
service per patient, and cardiology requires eight, nine
and ten hours. So, this is just to show how unrealistic
those figures are, and I think we should stop using
them or try to get some new tools to measure what we
want to measure.



MISS CRAWFORD: We agree with this very much.

THE CHAIRMAN: Thank you very much Miss Crawford and your associates for this information you have given us, which is very valuable and, of course, ultimately will fit in in its proper place with the other information we gather from province to province. As I mentioned earlier, we are grateful to you for having waited over to give this presentation tonight and for having done so with so much grace.

MISS CRAWFORD: Thank you Mr. Chairman and Commissioners for listening to our submission.



THE CHAIRMAN

THE CHAIRMAN: Thank you very much, Miss Crawford, and your associates for the information you have given us, which is very valuable and, of course, ultimately will fit in in its proper place with the other information we gather from province to province. As I mentioned earlier, we are grateful to you for having waited over to give this presentation tonight and for having done so with so much grace.

MISS CRAWFORD: Thank you, Mr. Chairman and Commissioners for listening to our submission.



THE CHAIRMAN: We will now have the submission of the Saskatchewan Farmers' Union.

SUBMISSION OF THE SASKATCHEWAN FARMERS' UNION

APPEARANCES:

MR. A.B. GLEAVE - President

MRS. TREW - Women's President

MR. S. THIESSON - Secretary

---EXHIBIT NO. 85: Submission of the Saskatchewan Farmers' Union.

MR. GLEAVE: Mr. Chairman and Commissioners, we appreciate very much your continuing tonight to hear us. Mr. Thiesson, our Secretary, will summarize the brief to start it off.

MR. THIESSON: Mr. Chairman and Commissioners, while we are known in this Province as probably having the most progressive labour laws across the Country, it apparently does not apply to Commissions.

THE CHAIRMAN: Nor the representatives of the farmers' organizations.

MR. THIESSON: The Saskatchewan Farmers' Union is a voluntary membership organization representing approximately 20,000 farm families across Saskatchewan. The philosophy of our organization embraces concepts which recognize the need for the social well being of people



We will now have the submission

of the Saskatchewan Farmers' Union

SUBMISSION OF THE SASKATCHEWAN FARMERS' UNION

President

Secretary

Mr. J. H. Thompson

MEMORANDUM NO. 101: Submission of the Saskatchewan

Mr. Thompson, Mr. Chairman and Commissioners,

We appreciate very much your continuing tonight to hear us, Mr. Thompson, our Secretary, will summarize the

points to start us off.

MR. THOMPSON: Mr. Chairman and Commissioners,

while we are known in this Province as probably having the most comprehensive labour laws across the Country, it apparently does not apply to Commissioners.

THE CHAIRMAN: Now the representatives of the

farmers' organizations.

MR. THOMPSON: The Saskatchewan Farmers' Union

is a voluntary membership organization representing ap-

proximately 20,000 farm families across Saskatchewan.

The philosophy of our organization embraces concepts which

recognize the need for the social well being of people



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3 generally. Our farm women in particular have a long-
4 standing record of social service in the field and have
5 carried on such programmes or projects as cancer re-
6 search, and retarded children research, and also rehabi-
7 litation funds for mental patients.

8 Our forebears in this organization date back to
9 1901 to the Territorial Graingrowers Association, and our
10 policy on medical care and hospitalization care, as early
11 as we can find out, dates back to approximately 1914. I
12 expect the Commission is by this time aware of the grow-
13 ing complexity of health and welfare needs across Canada
14 that confront modern society, and this together with the
15 fact of rising costs means that Government is being re-
16 quired to assume an increasing role in taking part to
17 maintain and improve national health standards. One of
18 the major areas of concern for rural people has always
19 been that medical and hospital care should be within a
20 reasonable distance of its people. To this end municipal
21 doctor schemes have been started over the years, and you
22 are aware of that, and also of the introduction of the
23 Swift Current health region, which you heard about today.
24 We do not wish to dwell on the interim report of the
25 Committee which made the study in this Province except
26 to point out there are in it, we believe, two significant
27 figures on this general subject. One is that there are
28 approximately 33 percent of the population of the Prov-
29 ince at the present time which does not have any form of
30 medical care insurance. The other is that there is a
considerable percentage of people that were reported in
1959 in this Province as being non-taxable for purposes



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4 of income tax. This was in the form of 40 percent of
5 those who filed on married status, and 28 percent for
6 single status. We conclude from this there are a consider-
7 able number of people in a low income bracket and that
8 of this number there may be a number who do not presently
9 carry medical care, and that they themselves may be those
10 who are greatest in need of the medical care programme.

11 Our organization made its representations to
12 the Provincial Committee, and we recommended a medical
13 care plan for the Province that would provide the op-
14 portunity of obtaining medical attention regardless of
15 financial or physical circumstances; provide greater
16 uniformity in medical care than is now possible under
17 existing plans; that it should be administered by the
18 Province; and should be active in the research and pre-
19 ventive fields.

20 We support a national health programme which
21 would embody some of the following: a universal medical
22 care programme covering all people which will provide
23 the costs of medical attention from a licenced practition-
24 er when required; provide dental and optical care and
25 prescription drugs; permit the patient the freedom of
26 choice of his physician at all times; recognize the
27 principle of "fee for service" where practical; inte-
28 gration of a medical care programme with existing hospi-
29 tal care programmes; sharing by the Federal Government
30 of hospital costs such as mental and tuberculosis in-
stitutions and home care programmes; health programme
financed through Federal and Provincial revenues and
personal contributions based on taxable incomes; a



of income tax. This was in the form of 40 percent of those who filed on married status, and 28 percent for single status. We conclude from this there are a considerable number of people in a low income bracket and that of this number there may be a number who do not presently carry medical care, and that they themselves may be those who are greatest in need of the medical care programme. Our organization made its representations to the Provincial Government, and we recommended a medical care plan for the Province that would provide the opportunity of obtaining medical attention regardless of economic status. It is our belief that it is now possible under existing plans, that it should be administered by the Province, and should be a factor in the research and preventive fields. We support a national health programme which would embody some of the following: a universal medical care programme covering all people which will provide the costs of medical attention for a licensed practitioner or when required provide dental and optical care and prescription drugs, covering the treatment the freedom of choice of his physician at all times; recognize the principle of "free for service" where practicable; insurance of a medical care programme with existing hospital care programmes; sharing by the Federal Government of hospital costs such as mental and tuberculosis institutions and home care programmes; health programmes financed through Federal and Provincial revenues and personal contributions based on taxable incomes; a



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3 programme to be administered by a national body to act
4 as a co-ordinating agency in the operations of the nation-
5 al health programme at Provincial levels and which will
6 in the course of its operations concern itself with such
7 things as: (i) Direct and encourage research programmes
8 of both a medical and statistical nature which have value
9 to the welfare of the nation as a whole.

10 (ii) Plan and co-ordinate rehabilitation pro-
grammes and facilities within Canada.

11 (iii) Negotiate with the national professional
12 organizations representing practitioners involved in the
13 programme.

14 We think some of the advantages of a national
15 health plan include uniformity of service throughout the
16 Country; the removal of difficulties that arise because
17 of the movement of population from one part of Canada to
18 another; and that it could be based on the broadest pos-
sible tax base available.

19 One of the problems, of course, is constitution-
20 al, and it may therefore come to pass that a national
21 health programme would be limited to Federal-Provincial
22 participation where provinces would have the option of
23 taking part, as is the case in the hospital programme.
24 In the event of such an occurrence happening, we would
25 outline that there should be safeguards in such a pro-
26 gramme that when a province does participate it will not
27 close the opportunity to making it indeed a truly nation-
28 al programme at some future date, presumably when all
provinces have made the decision to enter the programme.

29 With respect to such a programme we believe
30



one of the problems involved would be there may be a wide variation in the services offered in the individual provinces, and as a result there may be a minimum standard of health services which would become the criteria for the Provincial plans.

We recommend greater Federal participation in grants for hospital construction. However, at the same time we note there is a wide variation in the number of general hospital beds throughout Canada ranging from approximately 41.6 to 66.5 per 10,000 population. We point out in the event of a medical care programme being introduced there may be increased pressure for further hospital construction in the Provinces where there would be a greater demand made by the hospitals as a result of the medical care plan being implemented.

We are concerned by the increased number of patients entering for mental treatment. This number has approximately doubled in ratio per one hundred thousand over the last twenty years, and it would indicate to us that there is required greater construction in the field of mental hospitals and institutions, and improved facilities.

We recommend that there be increased grants towards research.

We note that Canada ranks 13th among civilized countries in deaths caused by heart disease, 12th in infant mortality and 9th in maternal mortality, which indicates these are areas in which further research should be undertaken; also in terms of the effects of alcohol and tobacco on the human body are among these.



We also recommend an improved programme of bursaries to attract more competent people to the research field.

In the field of rehabilitation we conclude that these are not now as accessible as we believe is desirable, and the problem to rural people, particularly rehabilitation, is that these are often not located within reasonable distances of the people requiring treatment. Also rehabilitation centres, we believe, should be investigated and might be interprovincial in nature and provide for treatment for victims of industrial or farm accidents.

We recommend the implementation of a home care programme to meet the needs of patients who may be better cared for outside hospitals, and you have had some discussion of that this evening.

We draw your attention to the findings of the Restrictive Trade Practices Commission in regard to the drug industry in Canada in which they noted that the cost of drugs in Canada is among the highest in the world, and there are a number of reasons which they have outlined for this, one of them being the multiplicity of similar types of drugs offered for sale, and the fact that there is a sales tax applied against drugs in Canada which does not prevail in other Countries.

We would request that Federal action be required to control drugs and the cost to consumers, and that more rigid controls be imposed by the Federal Government to avoid the offering on the market of the large multiplicity of similar type drugs.

In conclusion, we believe that the general



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4 health and welfare of its citizens should be a matter of
5 direct concern to any nation, and if this basic require-
6 ment cannot be adequately fulfilled, then there exists
7 individual privation and a loss of human dignity which
8 becomes a charge on the whole of society.

9 In a nation as wealthy in resources and re-
10 sourcefulness as is Canada, there must be brought into
11 existence a state or priority which will establish an
12 adequate programme of health care as a basic right of all
13 citizens.

H/je 14 THE CHAIRMAN: Thank you very much. As I said
15 in connection with the last two submissions who were here,
16 this indicates a great deal of plot and preparation and
17 of trying to work out a programme which in your view might
18 have some possibility of being accepted over a period of
19 time. On page 5, paragraph 20 you say:

20 "We would not recommend, for example, that a
21 Province under a Federal-Provincial programme be permitted
22 to launch a programme under the control of private
23 interests."

24 The "private interests", would you there ex-
25 clude a co-operative consumer organization?

26 MR. THIESSON: Yes, I think we would.

27 THE CHAIRMAN: You would exclude them?

28 MR. THIESSON: Yes.

29 THE CHAIRMAN: So that I might understand, you
30 would not want the programme run by a co-Op?

MR. THIESSON: No, I think not. The other
members of the group can reply to that but I think our
concept here is that the programme would be under

health and welfare of its citizens should be a matter of direct concern to any nation, and if this basic requirement cannot be adequately fulfilled, then there exists individual privation and a loss of human dignity which

In a nation as wealthy in resources and resourcefulness as is Canada, there must be brought into existence a state of emergency which will establish an associated program of health care as a basic right of all

in connection with the last two assumptions was made here. This indicates a great deal of time and preparation and of trying to work out a program which in your view might have some possibility of being accepted over a period of

time. On part of paragraph 10 you say: "We want a new responsibility for example, that a Province under a Federal-Provincial programme be permitted to launch a scheme under the control of private

interests." The "private interests", would you there expect a co-operative consumer organization?

Well, I don't want to program you by a co-op. Mr. THORNTON: No, I think not. The other members of the group can reply to that but I think our concept here is that the programme would be under



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3 Government control and if a co-operative was regarded as
4 a private group well then certainly it is excluded.

5 MR. GLEAVE: A co-operative is essentially a
6 voluntary operation and it would mean that some people
7 would be in and some people would be out and we would not
8 think of such an approach.

9 THE CHAIRMAN: I appreciate what you said but
10 it is not what I had in the context of my question that
11 even if it was applied to everybody that it might still
12 be administered by a co-operative group, non-profit co-
operative group.

13 MR. GLEAVE: I do not think -- this is not an
14 all-inclusive health plan as we see it. I think our
15 answer to this would still be no.

16 THE CHAIRMAN: You want it government operated?

17 MR. GLEAVE: Yes.

18 MR. THIESSON: A government operated programme
19 should be non-profit in its approach to the question.

20 THE CHAIRMAN: Financially, you mean?

21 MR. THIESSON: Yes, there may be a deficit, too.
22 There have been other suggestions in this regard and one
23 was raised by some question of voluntary approach and I
24 think that was raised today and also in Manitoba. How-
25 ever, there is one aspect about a voluntary approach, I
26 think, that is worthy of comment and that is if a Federal
27 Government provides a grant to the province for a volun-
28 tary scheme that means that all the taxpayers in the
29 province will be sharing in the cost of the premium in
30 each province but they might not possibly be obtaining
any of the benefits unless they subscribe in addition.



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MR. TILLY: Yes.
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tary scheme that means that all the taxpayers in the
province will be sharing in the cost of the premium in
each province but they might not necessarily be obtaining
any of the benefits unless they subscribe in addition.



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4 COMMISSIONER McCUTCHEON: What you are saying
5 is a federal subsidized voluntary scheme becoming in the
6 final analysis almost compulsory?

7 MR. THIESSON: Well, everybody would be paying
8 into it if they are paying taxes.

9 COMMISSIONER McCUTCHEON: The answer is yes,
10 then.

11 THE CHAIRMAN: Do you support the idea of a premium
12 in any provincially constituted programme either as part
13 of the national programme or under provincial sponsorship?

14 MR. THIESSON: In our approach to the province
15 on this question we ask that it be on a -- that there be
16 a premium charged to each of the people that would be
17 receiving the benefits in this approach on a Federal plan.
18 You will note we said it should be based on a taxable
19 income basis. Now, it could involve a combination of these
20 depending on the results of research that could possibly
21 estimate the cost to the nation as a whole. It is pos-
22 sible that it would include both the premium and a tax
23 or simply a tax.

24 THE CHAIRMAN: And if it is a tax you think
25 on an income basis?

26 MR. THIESSON: This would recognize to some
27 degree the ability to pay on the part of the nation as
28 a whole.

29 THE CHAIRMAN: If we accept this and this is
30 only hypothetical, some estimates have been made that the
cost of nation-wide complete coverage, comprehensive
medical plan, would cost in the neighbourhood of a bil-
lion and a half dollars.



COMMISSIONER McCUTCHON: What you are saying is a federal subsidized voluntary scheme becoming in the

into it if they are paying taxes.

COMMISSIONER McCUTCHON: The answer is yes,

then.

THE CHAIRMAN: Do you support the idea of a health in any provincially controlled programs either as part of the national program or under provincial sponsorship? MR. THOMPSON: In our approach to the province on this question we ask that it be on a -- that there be a premium charged to each of the people that would be needed in the benefits in this approach on a Federal plan.

You will note we said it should be based on a taxable income basis. Now, it could involve a combination of these depending on the results of research that could possibly estimate the cost to the nation as a whole. It is possible that it would include both the premium and a tax or simply a tax.

THE CHAIRMAN: And if it is a tax you think

on an income basis?

MR. THOMPSON: This would recognize to some degree the ability to pay on the part of the nation as a whole.

THE CHAIRMAN: If we accept this and this is only hypothetical, some estimates have been made that the cost of nationwide complete coverage, comprehensive medical plan, would cost in the neighborhood of a billion and a half dollars.



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4 MR. THIESSON: Pretty near the same as the
5 defence budget?

6 THE CHAIRMAN: Just about and that the total
7 income tax collection in the year 1960 was in the order,
8 I think, of \$1,600,900,000.

9 MR. THIESSON: Well, there are different ways
10 of looking at this as I am sure you will appreciate by
11 this time. But, the fact remains that to the majority
12 of people in Canada at least -- well, let us take Sas-
13 katchewan, there are 67 percent now under some form of
14 programme either direct government subsidy or --

15 THE CHAIRMAN: That is for the group that we
16 heard mentioned as the indigent class?

17 MR. THIESSON: Yes. Well, it could be that is
18 one that government provides care for or there are people
19 who belong to medical services or group medical co-ops
20 for this type of programme. In one way or another the
21 money involved for doctor care, hospitalization care and
22 so on is being paid for not through taxation; it is being
23 paid directly or through a combination of hospitalization
24 tax and similarly costs for optical care, prescription
25 drugs and so on are also being paid by the people who
26 require these services. I wonder if the cost to the
27 nation as a whole in providing it in this manner is not
28 probably in excess of \$1.5 billion per year? It is just
29 a matter of economics as to whether it would be more
30 economic to provide it to the nation as a whole through
an organized plan or whether it would be more economical
to provide it to them as things presently are on a laissez
fair basis and maintain the status quo. There is more



reference budget.

THE CHAIRMAN: Just about and that the total income tax collection in the year 1950 was in the order,

MR. THOMPSON: Well, there are different ways of looking at this as I am sure you will appreciate by this time. But, the fact remains that to the majority of people in Canada at least -- well, let us take Saskatchewan, there are 50 persons per square mile of population either direct government subsidy or --

THE CHAIRMAN: That is for the group that we have mentioned as the indigent class.

MR. THOMPSON: Yes, well, it could be that is one that government provides care for of these are people who belong to medical services or group medical societies for this type of program. In one way or another the money involved for doctor care, hospitalization care and so on is being paid, or not through insurance, it is being paid directly or through a combination of hospitalization tax and similarly costs for optical care, prescription glasses and so on are also being paid by the people who require these services. I wonder if the cost to the nation as a whole in providing it in this manner is not probably in excess of \$2.5 billion per year. It is just a matter of accounting as to whether it would be more economic to provide it to the nation as a whole through an organized plan or whether it would be more economical to provide it to them as things presently are on a laissez-faire basis and maintain the status quo. There is more



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4 than one way of assessing the costs. I mean cost, the
5 cost is there now but the fact remains that there are
6 people perhaps within our society who are not able to
7 avail themselves adequately of these services because of
8 financial circumstances or other circumstances.

9 COMMISSIONER McCUTCHEON: Why would you object
10 to a plan that would take care of that group of people?

11 MR. GLEAVE: Which group?

12 COMMISSIONER McCUTCHEON: The group that cannot
13 take care of themselves?

14 MR. GLEAVE: I do not know how you would define
15 them. For instance, in this province we have had a crop
16 failure which has cut people's income severely. Well
17 now, are you going to go to a man, say he has 50 head of
18 cattle, he has his breeding stock there and he has a
19 hospital bill of \$500. Do you say to him --

20 COMMISSIONER McCUTCHEON: I do not think we
21 were talking about hospital bills.

22 MR. GLEAVE: I think we are talking about a
23 health plan which is what I am thinking of which includes
24 medical bills or various bills that are concerned or in-
25 volved. In such an instance would you say in effect
26 "Well, you reduce your working capital by this much and
27 reduce your medical bill."?

28 COMMISSIONER McCUTCHEON: You have not told me
29 what money he has in the bank.

30 MR. GLEAVE: Well, whatever is the case.

COMMISSIONER McCUTCHEON: That is what bank
accounts are for.

MR. GLEAVE: The point I am making is this:



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4 How do you define when this man becomes unable to pay?
5 I do not know at what point you can define this. You
6 may say the same thing to a man living in town, you say
7 "You have a \$5,000 equity on your house, liquidate this
8 and pay it." I do not know how you arrive at a point
9 where a man can or cannot pay in this sense.

10 THE CHAIRMAN: That is one of the difficulties
11 with the problem that arises in any type of programme
12 that may be suggested particularly where there is a
13 premium involved. For instance, under the proposed
14 programme in Saskatchewan a single person is required to
15 pay \$12. a year and \$24. a year for a family. Regardless
16 of any other factor unless that premium is paid either by
17 the person or on his behalf he does not get a card en-
18 titling him to medical services.

19 MR. THIESSON: This raises a point.

20 THE CHAIRMAN: We still have to find a formula
21 for that category of persons who are unable to pay the
22 premium, the \$12. or the \$24. We come to it every time,
23 do we not?

24 MR. GLEAVE: Generally in the Hospital Services
25 Plan I believe what they do in the case of an indigent
26 or a person actually on social welfare, then the munici-
27 pality or urban or rural pays the fee, in this case, but
28 only as a general --

29 THE CHAIRMAN: Yes, because that is definition,
30 that is the way that group has come to be identified.

MR. GLEAVE: That is right.

THE CHAIRMAN: Then there would be a matter of
finding some way if a way could be found of identifying



How do you define when this man becomes a male to pay?

I do not know at what point you can define this. You may say the same thing to a man living in town, you say "You have a 25,000 property on your house, I consider this and pay it." I do not know how you arrive at a point where a man can or cannot pay in this sense.

THE CHAIRMAN: That is one of the difficulties with this question that we are in any case of property. It is not a question of whether or not there is a premium involved. For instance, under the proposed programme in Saskatchewan a single person is required to pay \$15 a year and \$10 a year for a family. Regardless of any other factor unless that person is said either by the person or on his behalf he does not put a cent on it. I think him to be a male.

MR. CHAIRMAN: We still have to find a formula for that category of persons who are unable to pay the premium, the 25% or the 50%. We come to it every time, do we not?

Then I believe what they do in the case of an individual on a person not able to pay the premium, then the municipality or other or federal pays the fee. In this case, but only as a person.

THE CHAIRMAN: That is right. That is the way that group has come to be identified.

THE CHAIRMAN: Then there would be a matter of finding some way if a way would be found of identifying



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3 the group above that level and below the level where a
4 person can be said to be able to afford the premium.
5 There is, I think it was described to us by one person,
6 as the grey area, the graduated area. Now, if that group
7 can be defined as in some way similar to the lower group
8 and its needs taken care of, that would leave those who
9 are able to pay to look after themselves. What would you
10 say as to a programme of that kind?

11 MR. THIESSON: In a case like that, of course,
12 you are suggesting there would be a limited coverage,
13 that is by Government.

14 THE CHAIRMAN: Not a limited coverage, a limited
15 premium.

16 MR. THIESSON: Let us take Saskatchewan, for
17 instance, they are suggesting \$24. per family. Well, in
18 my case I am paying \$84. right now to Medical Services
19 and I am not necessarily elated at the fact I may be able
20 to get a similar type of coverage under a provincial plan
21 for \$24.

22 THE CHAIRMAN: You know you are paying more
23 than \$24?

24 MR. THIESSON: Yes, either indirectly or direct
25 tax, either one way or another and I possibly could pay
26 more directly than \$24. But, if I pay \$84 to a provinc-
27 ial plan maybe, as one citizen I would be getting this
28 in terms of the total, my dollar would be going further
29 than it would be at the present time, that is by pro-
30 viding for the people who are not able to provide for
themselves.

MRS. TREW: I think perhaps not enough has



person can be said to be able to afford the premium.

There is, I think it was described to us by one person,

as the very best, the graduated area.

and its needs taken care of, that would leave those who
are able to pay to look after themselves. That would you
say as to a program of that kind?

MR. THOMPSON: In a case like that, of course,

you are suggesting there would be a limited coverage,

that is by Government.

THE CHAIRMAN: Let a limited coverage, a limited

MR. THOMPSON: Let me take that question for

my case I am paying \$24, right now to medical services

and I am not necessarily elated at the fact I may be able
to get a similar type of coverage under a provincial plan

THE CHAIRMAN: Now how you are paying more

than \$24?

MR. THOMPSON: Yes, either indirectly or direct

tax, either one way or another and I possibly could pay

more directly than \$24. But, if I pay \$24 to a province-

ial plan maybe, as one citizen I would be getting this

in terms of the total, my dollar would be going further

than it would be at the present time, that is by pro-

viding for the people who are not able to provide for

themselves.

MR. THOMPSON: I think perhaps not enough has



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4 been made of the difficulty that our President mentioned
5 of determining this group. This is especially difficult
6 in a rural area in a rural province especially agri-
7 cultural because of the wide fluctuation of income and
8 the fact that people who, in a farming business, are
9 operating on a fairly marginal level. Not this group
10 one of your Commissioners referred to as having money in
11 the bank but the other kind where one year he would
12 definitely not be able to pay and the next year he would,
13 I think that when there is a government programme and
14 the premiums are collected through taxes there is a pos-
15 sibility of flexibility with regard to a municipality
16 paying and collecting again at a later time that would
17 not be possible under a proposal where there would neces-
18 sarily be a means test. Some of these people would do
19 without medical care rather than undergo any means test;
20 many of them would, I think. That is a person who is
21 ordinarily self-supporting.

22 COMMISSIONER VAN WART: By "they" you mean the
23 families, you mean families go without medical care?

24 MRS. TREW: Naturally.

25 COMMISSIONER BALTZAN: Would you help me out in
26 this paragraph 3 on the first page where you say:

27 "In the event of a national health plan being
28 implemented on a Federal-Provincial basis and
29 falling short of the objective we have outlined,
30 such a programme must proceed only along lines
which will enable the realization of a completely
national health plan -- "

I seem to gather the meaning implies a uniform



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3 plan across the whole nation, perhaps similar in every
4 province or every province being alike. What is the ex-
5 act meaning of that?

6 MR. THIESSON: You are looking under the sum-
7 mary, are you?

8 COMMISSIONER BALTZAN: Yes, Paragraph C.

9 THE CHAIRMAN: Perhaps it would be better to
10 look at Paragraph B where your objective is a national
11 health plan.

12 MR. THIESSON: Yes, it is.

13 THE CHAIRMAN: I think the question is more
14 appropriately addressed to Paragraph B than to Paragraph
15 C.

16 MR. THIESSON: Yes, I think it is.

17 MR. GLEAVE: I think it has reference to the
18 transition.

19 THE CHAIRMAN: That is C, but B is what you
20 would like.

21 MR. GLEAVE: That is right.

22 THE CHAIRMAN: Would you answer Dr. Baltzan's
23 question on that basis?

24 MR. THIESSON: I think his question was if we
25 visualized a uniform system across Canada and the answer
26 is yes, that is in terms of service provided.

27 COMMISSIONER BALTZAN: You think that would be
28 a good thing if you have a standardized form in every
29 province all alike? I am thinking in terms of making
30 provision for particulars to apply to the circumstances
each province has as against another province.

MR. THIESSON: You mean financial circumstances?



plan across the whole nation, perhaps similar in every province or every province being alike. What is the ex-

MR. THORNTON: You are looking under the sun-

many, are you?

COMMISSIONER BARTON: Yes, paragraph C.

THE CHAIRMAN: Perhaps it would be better to

look at paragraph B where your objective is a national

MR. THORNTON: Yes, it is.

THE CHAIRMAN: I think the question is more

appropriately addressed to paragraph B than to paragraph

MR. THORNTON: Yes, I think so.

MR. CHASE: I think it was referred to the

THE CHAIRMAN: What is C, sir? Is what you

would like?

MR. CHASE: That is right.

THE CHAIRMAN: Well, you answer C, sir?

question on that basis?

MR. THORNTON: I think his question was it was

visualized a national water control system and the answer

is yes, that is in terms of service provided.

COMMISSIONER BARTON: For think that would be

a good thing if you have a standardized form in every

province all alike. I am thinking in terms of making

provision for particular to apply to the circumstances

each province has as against another province.

MR. THORNTON: You would furnish circumstances



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4 COMMISSIONER BALTZAN: Financial and even re-
5 search native to the province.

6 MR. THIESSON: Well, there I think in terms of
7 provincial finance. First of all, let me say this, that
8 if you have a truly national scheme then as a citizen of
9 Canada you will be able to get equal service no matter
10 where you go. Now, in terms of research if you had a
11 national co-ordinating body that looked at the research
12 end of the nation as a whole it could allocate these re-
13 search programmes where they were required.

14 COMMISSIONER BALTZAN: I have no reason to ob-
15 ject to your statement at all, I am just asking for an
16 enquiry because there is a great element of individualism
17 amongst us in Canada.

18 MR. THIESSON: Yes, I have heard about it.

19 COMMISSIONER BALTZAN: That prompts me to put
20 that question to you. Now, on page 2, no. 6:

21 "Canada is, nonetheless, lagging behind many
22 other civilized nations in respect to providing
23 comprehensive health care coverage for its
24 citizens."

25 Lagging behind in the comprehensive health
26 coverage of lagging behind in that it has not got a plan
27 for comprehensive coverage?

28 MRS. TREW: Well, I think the word "coverage"
29 is a key word there, the plan. We are referring in this
30 case to the fact that many other countries, for instance,
in Europe, have provided comprehensive health care cover-
age for all their citizens.

COMMISSIONER BALTZAN: Would one deduce from



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3 that that perhaps the state of health of the nation, our
4 nation, is as a result of that inferior to the state of
5 health in other civilized nations where there is a com-
6 prehensive plan?

7 MRS. TREW: We will say that the care for many
8 of those citizens is less.

9 MR. GLEAVE: I think you might assume this if
10 you take a country such as the United Kingdom where the
11 diet of the children is part of the concern of this great
12 plan, where the diet and other matters are part of this
13 health plan you may safely assume that since some of the
14 health needs of our country are not being looked after
15 as closely, might assume our health standards will be
less, the actual health and physical fitness.

16 COMMISSIONER BALTZAN: In other words, in con-
17 nection with the health services, you are then including
18 other sociological elements and deficiencies in those
areas?

19 MR. GLEAVE: Yes.

20 COMMISSIONER BALTZAN: It is not only because
21 of say the treatment of cases?

22 MR. GLEAVE: Yes, I think you would have to
23 include this.

24 COMMISSIONER BALTZAN: Thank you very much.

25 MRS. TREW: Mr. Chairman and Commissioner, I
26 think you will notice perhaps in our brief we speak of
27 health care, not necessarily always medical practitioner
28 service, we speak of health services, to include other
things.

29 COMMISSIONER BALTZAN: I appreciate your
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4 remark. We have tried to bring that out so many times,
5 and so many people have overlooked just exactly what you
6 are stressing. One other thing: "One of the major con-
7 cerns for people in rural areas in this province has been
8 to have medical and hospital care within reasonable ac-
9 cess to its citizens." I agree that this has been a
10 very much more serious matter than it is now. I put
11 this to you in this way. It has been said, and I think
12 you have already said here this evening, the rural popu-
13 lation is definitely going urban. There is a tendency
14 that way. Then, to comply with this, and to meet the
15 needs of this increasingly sparse area of population, you
16 sort of want to reverse the force. You would like to see
17 it done in bringing doctors' and nurses' teams to these
18 areas, when the trend is away from these areas as far as
19 concentration of population, and in face of that you
20 would like to see whatever can be done to reverse the
21 current. That is, have doctors close at hand and nurses
22 close at hand?

23 MR. GLEAVE: Yes.

24 COMMISSIONER BALTZAN: Even if it is against
25 the general trend as it is today?

26 MR. THIESSON: I don't think that you are going
27 to reverse the trend. Are you suggesting that we are
28 suggesting that there should be more hospitals built in
29 rural areas?

30 COMMISSIONER BALTZAN: No, I would like to see,
in view of that, how that can be accomplished. How it
can be done here. The population is swinging in this
direction, and because of that the area that is left



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3 behind is less populated.

4 MR. THIESSON: Yes, what we are really saying
5 is that this is really a statement more than anything.

6 COMMISSIONER BALTZAN: Yes, but it is a fact?

7 MR. THIESSON: It is a fact as well, I hope
8 it is a statement of fact, yes.

9 COMMISSIONER BALTZAN: You say people should
10 have immediate recourse to treatment and emergency
11 treatment, etc., and the nurses have spoken about this
12 just before you started, and there is a serious problem
13 and it is becoming an increasingly more serious problem.
14 Do you think there is a mitigating circumstance in that
15 today we have all around roads for instance, and going
16 to see a doctor 50 miles is much easier than it was in
17 our earlier days, Mr. Gleave, to go just eight miles into
18 town?

19 MR. GLEAVE: Yes, certainly, because I remember
20 in the area where I live, somebody had to take a snow
21 plane. Maybe some of these people from the east don't
22 know what a snow plane is.

23 COMMISSIONER VAN WART: I owned one in 1932.

24 MR. GLEAVE: Maybe this had to be relied on,
25 or a team of horses in the winter, and we have overcome
26 some of these things, and I think such things as the
27 Swift Current health region stabilizes things in a
28 sparsely settled area, and ensures that services will
29 be available to that sparsely settled area, and the
30 medical profession themselves too, have set up in our
main centres and set up much better services than there
were let us say 20 years ago. Those doctors themselves



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3 have done this in many instances.

4 COMMISSIONER BALTZAN: Mr. Gleave, just to
5 complete that. I had a shocking statement made to me
6 on a number of occasions say in a community, X let us
7 call it, where I would say to the local doctor: "I
8 suppose that you have to go out in the winter, or even
9 in the summer, lots of times on the farm, to see some-
10 body ten, twelve miles away.", and he said, surprisingly,
11 "We have less of that to do than we have ever had to do
12 before, what with the telephone and the accessibility of
13 roads to save the patient time and bring him back where
14 we can, to give him the proper kind of care in the
15 hospital, they are brought to the hospital." I asked
16 him in connection with a fractured leg.

17 MR. GLEAVE: Well, there is more tendency I
18 believe in the rural areas to bring the patient in,
19 rather than for the doctor to go out, and part of this
20 is of course because if he brings him in there is a
21 hospital there, he has more facilities at his hand to
22 deal with the situation that he is going to face, but
23 I still think the doctors go out when they need to go.

24 COMMISSIONER BALTZAN: I don't doubt that at
25 all, but I am just pointing out that there has been
26 a swing in the trends of things.

27 MR. GLEAVE: Well, obviously you can load,
28 you can place a sick person in a car that is heated,
29 and bring him 20 miles to town, where you couldn't put
30 him in a sleigh and bring him down 20 miles. He might
even be dead when you got there.

COMMISSIONER BALTZAN: You also save time in



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COMMISSIONER BARTON: Well, I have, just to
complete that, I had a check on statement made to me
on a number of occasions as to a community. I let us
call it, where I would say to the local doctor, "I
suppose that you have to go out in the winter, or even
in the summer, lots of times on the farm, to see some-
body else, that is, a doctor away," and he said, "Surprisingly
"We have been out there in the winter, and we have had to be
out, what with the temperature and the accessibility of
roads to save the time and the expense of going where
we can, to give him the proper kind of care in the
hospital, they are going to the hospital." I asked
him in connection with that, what was the
Mr. BARTON: Well, there is some tendency I
noticed in the local areas to have the patients
rather than the doctor to go out, and part of that
is of course because the doctor in there is a
hospital there, he has more facilities at his hand to
deal with the situation that he is going to face, but
I still think the doctors go out when they need to go.
COMMISSIONER BARTON: I don't know that at
all, but I am just pointing out that there is a
a sense in the needs of things.
Mr. BARTON: Well, certainly you can feel,
you can place a sick person in a car and go
and have him go down to town, where you couldn't put
him in a sleigh and bring him down 20 miles. He might
even be dead when you get there.
COMMISSIONER BARTON: You also have time in



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3 giving the patient the best service. Page 4, no. 3, on
4 the top of the page: "A prepaid medical care programme
5 should be administered by the Province or its duly ap-
6 pointed representatives." I am just wondering for my
7 own information where would the share of the municipali-
8 ties come in, because municipalities are rather anxious
9 to have a say in many of the things local to them. If
10 it is administered, governed as it were, and it is out
11 of their hands what would the municipality say about it?

12 MR. GLEAVE: Well, I don't think it was our
13 intention, or it wouldn't be our intention to exclude
14 local government if they felt they should be a part of
15 such a programme. They are in many of the hospital
16 schemes for example, and some of the hospitals are
17 jointly supported by a group of municipalities and so
18 on, and as presently some of our municipality doctor
19 schemes. It wouldn't be the intention to exclude local
20 government.

21 COMMISSIONER BALTZAN: In other words, it would
22 be taken in the way it is spoken, rather than the way
23 it is read here?

24 MR. THIESSON: This is referring to our
25 provincial committee on advice in medical care, and in
26 that respect I think it would not visualize -- possibly
27 a medical commission, possibly through the Department
28 of Health that would be the over-all governing body.
29 You may, if you divide your medical care programme on
30 a provincial level into a regional basis, you would have
regional boards.

COMMISSIONER BALTZAN: But you would definitely



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3 want to have a say in the matter in your own area?

4 MR. THIESSON: There are always ways of re-
5 medying these things if you feel you do not have enough
6 control. You just change the government, and get one
7 that promises you more control. This is always in the
8 realm of possibility.

9 COMMISSIONER McCUTCHEON: The word promises is
10 the governing one in that.

11 MR. THIESSON: This is how governments win
12 elections. They do not always carry them out, they
13 sometimes get elected that way.

14 COMMISSIONER VAN WART: Do you believe that
15 the system which you have advocated here, as a result
16 of this system will give better medical care to the
17 people in your district, that is your over-all plan
18 which you advocate?

19 MR. THIESSON: For the province?

20 COMMISSIONER VAN WART: Yes, for the province?

21 MR. THIESSON: Well, we pointed out in our
22 representations to the province that at the present
23 time there are, I think we have the number here, 129
24 municipalities in the province that are under some form
25 of doctor care plan. There are nearly 300 municipalities
26 in the province, and 75 additional ones are in the Swift
27 Current health region, which is a total of about 204.
28 That leaves about 100 municipalities where there is no
29 type of programme of any kind in operation.

30 Some of these municipalities that are in a
municipal plan provide only the minimum type of care
to the ratepayers in the municipality. Others have a



want to have a say in the matter in your own area?

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Some of these municipalities that are in a municipal plan provide only the minimum type of care to the ratepayers in the municipality. Others have a



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3 broad type of care similar to the broadest type of
4 medical service offered.

5 COMMISSIONER VAN WART: Your answer to my
6 question is yes?

7 MR. THIESSON: Yes, that is right, it would be.

8 COMMISSIONER VAN WART: Or do you mean that
9 under your plan medical care would be more available to
10 the people?

11 MR. THIESSON: Well, it would be compulsory,
12 as we visualize it.

13 COMMISSIONER VAN WART: As you visualize it,
14 medical care would be more available to the people?

15 MR. GLEAVE: Let us say it would be more com-
16 plete coverage.

17 MR. THIESSON: More uniform.

18 COMMISSIONER VAN WART: You heard here about
19 the shortages of nurses, and especially in your rural
20 areas, you heard of the shortages of psychiatrists, the
21 shortages in the mental health programme, the shortages
22 of personnel in many lines, and with all of these short-
23 ages, do you think that a medical care plan can be given
24 at present?

25 MR. THIESSON: Well, in this province the
26 government apparently thinks --

27 COMMISSIONER VAN WART: No, I mean what do you
28 think?

29 MR. THIESSON: I think it can, yes.

30 COMMISSIONER VAN WART: But don't you think
that a better medical care plan could be given if all
these other things, the money was taken to rectify all



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4 these other things first?

5 MR. THIESSON: Which other things?

6 COMMISSIONER VAN WART: The mental care, in-
7 creasing the nurses, the available personnel, training
8 people in health projects, how to administer a medical
9 plan and so on, etc.?

10 MR. THIESSON: Well, if you had all these other
11 things and people couldn't altogether afford to take
12 advantage of them, you would have a problem there too,
13 wouldn't you?

14 MR. GLEAVE: Well, when we started on a hospi-
15 tal plan, we didn't build the hospitals and say after
16 that we will start the Hospital Services Plan. We
17 established the Hospital Services Plan and then set out
18 to build the hospitals that would make the plan work.

19 THE CHAIRMAN: Hospitals are brick and mortar,
20 and can be built.

21 MR. GLEAVE: Yes.

22 THE CHAIRMAN: Can you build a doctor in the
23 same way?

24 MR. GLEAVE: No, Mr. Chairman, you don't build
25 a doctor and you don't build a farm. They become, and
26 they become as the need for them becomes, and as the
27 need is developed if this nation or this province de-
28 clared that there was going to be adequate health ser-
29 vice to its people, and set out on a programme to pro-
30 vide it, the doctors would appear, and the nurses and
the psychiatrists would appear.

COMMISSIONER VAN WART: How long?

MR. GLEAVE: I don't know. This does not

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MR. THOMPSON: Which other things?

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the psychiatrists would appear.

COMMISSIONER VAN WART: How long?

MR. CHAIRMAN: I don't know. This does not



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3 concern me.

4 THE CHAIRMAN: Mr. Gleave, are you aware that
5 in the U.K., the Country that has had this now for some
6 years, that they are not growing or forming sufficient
7 doctors out of their some 50 million population to take
8 care of themselves, and that they have to import from
9 Eastern, Southeast Asia, and other areas of the world,
10 some 4,000 doctors a year?

11 MR. GLEAVE: No, I was not aware of it, but we
12 also import doctors.

13 THE CHAIRMAN: But do you understand that in
14 doing that, that we are depriving -- those doctors are
15 required in the areas from which they come, and that we
16 are depriving those areas of the essential personnel that
17 properly belongs to that area, indigenous of those areas?

18 MR. GLEAVE: Well, we have done the same, Mr.
19 Chairman, and it would seem to me that if this has
20 happened in both Great Britain and our own country, under
21 two entirely different approaches, that what we really
22 should be looking to is what kind of training programme
23 should we have, and what steps can we take to ensure that
24 we do have enough of these kind of people.

25 THE CHAIRMAN: And would you accept then that
26 they should have a priority, before jumping in with the
27 plan?

28 MR. GLEAVE: I still think that the two should
29 be synonymous. I think one will give impetus to the
30 other. The declared intention would give impetus to this,
and those who are responsible for setting up such a plan
would also be responsible for --



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concern me.

THE CHAIRMAN: Mr. Grieve, are you aware that in the U.K., the country that has had this now for some years, that they are not growing or forming sufficient doctors out of their some 50 million population to take care of themselves, and that they have to import from Eastern, Southern Asia, and other areas of the world,

MR. GRIEVE: Yes, I was not aware of it, but we also report ourselves.

THE CHAIRMAN: But do you understand that in doing that, that we are depriving - those doctors are required in the areas from which they come, and that we are depriving those areas of the essential personnel that properly belong to that area, the situation of those areas?

MR. GRIEVE: Well, we have done the same, Mr. Chairman, and it would seem to me that if this has happened in both Great Britain and our own country, under two entirely different apertures, that what we really should be looking to is what kind of training programme should we have, and what steps can we take to ensure that we do have enough of these kind of people.

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4 COMMISSIONER BALTZAN: Are you aware of the
5 great concern and the complaints, the number of com-
6 plaints from people day by day, complaining about not
7 being able to get into a hospital, to get a hospital bed,
8 that have to stay around in the City for two or three
9 days, or longer, in a hotel? You must have heard it
10 from your neighbours. I hear it every day, that people
11 do talk about it, and they are blaming somebody, and here
12 is the problem. In 1947 hospitalization was established,
13 and in 1962 these people who have been paying for that
14 are doing the complaining about not being able to get
15 accommodation for which they have paid after fifteen years.

16 MR. GLEAVE: Yes, I am aware of it. If I want
17 to go to see the doctor who provided the spectacles that
18 I am wearing at the present moment, it will take me at
19 least a month to six weeks to get an appointment with
20 that particular doctor. I know this now, and I know the
21 doctor in the town where I used to live, who is an ex-
22 cellent man, I have seen him tired and worn to the bottom
23 of his shoelaces, and I know that the shortage of hospital
24 beds which you described, Dr. Baltzan, I know this also
25 exists.

26 MR. THIESSON: Would you suggest, Dr. Baltzan,
27 that because this shortage exists, that the hospital pro-
28 gramme should be scrapped?

29 COMMISSIONER BALTZAN: Not at all. We gave it
30 support originally, and we do now. I suggest that when
you start out in any kind of a plan, it is not the set-
up of the plan that is the important thing. Make pro-
vision for the things that that plan will require, and
then proceed.



COMMISSIONER KALIVAN: Are you aware of the

great concern and the complaints, the number of complaints from people day by day, complaints about not being able to get into a hospital, to get a hospital bed, that have to stay around in the City for two or three days, or longer, in a hotel? You must have heard it from your neighbors. I hear it every day, that people do talk about it, and they are talking somebody, and here is the problem. In the hospital system was established, and in 1913 these people who had been paying for that are doing the complaining and not being able to get

accommodation for which they have paid after fifteen years. Mr. Mayor, I am aware of it. I want to go to see the doctor who practices in a hospital that I am waiting at the present moment, it will take me at least a month to six weeks to get an appointment with that particular doctor. I know this now, and I know the doctor in this town where I used to live, who is an excellent man, I have seen him often and went to the hospital of his specialty, and I know that the shortage of hospital beds when you need them, is serious. I know this also

exists

support completely, and we do now. I suggest that when you start on any kind of a plan, it is not the set-up of the plan that is the important thing. Make provision for the things that that plan will require, and

then proceed



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4 MR. THIESSON: Well, I don't have them with
5 me, but I have seen statistics that indicated that when
6 the hospitalization plan was brought into effect in this
7 province. This is part of this reason for the creating
8 of hospital beds, due to the fact that doctors are making
9 greater use of hospitals by putting people into them for
observation.

10 COMMISSIONER BALTZAN: Is it doctors or people?

11 MR. THIESSON: Well, I don't think they can
12 go there unless the doctors send them.

13 THE CHAIRMAN: Well, I don't know, I don't
14 think I will go on with this debate much longer. I will
adjourn and we will take all day tomorrow.

15 COMMISSIONER VAN WART: I have one question,
16 Mr. Chairman. It is not debate, the reason I raised
17 this was we heard of shortage of the funds, and money
18 for health purposes, and a plan comes along now for
19 \$20 million expended. Do you feel that the inauguration
20 of your plan now, using that \$20 million, is better,
21 would give better health conditions in the community
22 than if you devote that \$20 million to improve the ser-
23 vices which are urgently needed to be improve first.
Now, that is the question I asked.

24 MR. THIESSON: Well, it is a matter of emphasis
25 probably. The \$20 million, a part of it is going to
26 come from the people in the form of premiums and taxes
27 that have been added on the sales tax. I don't know
28 whether you could get this money from the people if it
29 was going to be used strictly for the improving of
30 facilities and services. It is being got, and it is



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4 going to be obtained from the people on the basis of
5 providing them with a medical care programme. What you
6 raise is another problem, and what you say may be true,
7 but then on the other hand if what you say were done,
8 the money might not be there.

9 COMMISSIONER FIRESTONE: Mr. Chairman, Mr.
10 Gleave: does the Saskatchewan Farmers' Union support
11 the medical care plan as now being introduced by the
12 Saskatchewan Government?

13 MR. GLEAVE: Yes.

14 COMMISSIONER FIRESTONE: Are you in favour of
15 the methods of payment that have been suggested, and
16 that is the payment in part premium, part in taxes?

17 je MR. GLEAVE: I make myself clear on this point:
18 our convention has gone on record as being in favour of
19 a medical care plan. We submitted certain proposals to
20 them which I don't think included a direct payment by
21 the individual -- oh, Mrs. Trew tells me it did. So,
22 that being the case, I would say we are in favour of
23 the programme.

24 COMMISSIONER FIRESTONE: You are probably
25 familiar with the fact that the Saskatchewan Government
26 has suggested to the Royal Commission to suggest to the
27 Canadian Government that the Canadian Government pay
28 60 percent of the cost of the medical care services
29 programme: would you support such a contribution?

30 MR. GLEAVE: Yes, if we can get that much
assistance towards it we certainly would.

COMMISSIONER FIRESTONE: And judging from the
principles which you have outlined in your brief you



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4 would prefer that such a contribution be paid on the
5 basis of ability to pay and that you have described in
6 your brief through the system of income tax payments?

7 MR. GLEAVE: Yes. I think right here we
8 mention other sources besides income tax. Which page
9 are you referring to there? In the main it is through
10 the tax structure that we advocate here that it shall
11 be financed. I think it can stand that way.

12 COMMISSIONER FIRESTONE: Would the Saskatchewan
13 Farmers' Union support the necessary increase in income
14 taxes the Federal Government may have to impose in order
15 to distribute that 60 percent, because obviously that
16 money will have to be collected in taxes somehow, and
17 if the decision is that income tax is the best or most
18 available system on the basis of ability to pay, would
19 the Saskatchewan Farmers' Union support increases in in-
20 come tax to pay for that 60 percent?

21 MR. GLEAVE: Yes.

22 MR. THIESSON: It depends on what the formula
23 for increased income tax was.

24 COMMISSIONER FIRESTONE: Without getting in-
25 volved in the details of the formula, we are really dis-
26 cussing the principle, and the answer to the question is
27 "yes"?

28 MR. THIESSON: Yes.

29 COMMISSIONER FIRESTONE: You have also spoken
30 of being in favour of a national health plan, and you
envisage that as a comprehensive programme including
medical care, hospital benefits, etc., and you distinguish
the national health plan from what you call a plan based



would prefer that such a contribution be paid on the basis of ability to pay and that you have described in your brief through the system of income tax payments?

MR. STANLEY: Yes, I think right here we

mention other sources besides income tax. When you are you referring to them? In the main it is through the tax structure that we discuss here that it shall be financed. I think it can be done that way.

COMMISSIONER: I think it is the Secretary's

farmers' union support the system the case in income taxes the Federal Government may have to impose in order to distribute that 10 percent, because obviously that money will have to be collected in taxes somehow, and if the decision is that income tax is the best or most available system on the basis of ability to pay, would the Secretary's farm union support increases in income tax to pay for it or not?

MR. STANLEY: I think on what the formula

for increasing income tax was

COMMISSIONER: I think without getting in-

voiced in the case of the formula, we are really discussing the principle, and the answer to the question is

"yes?"

COMMISSIONER: I think you have also spoken

of being in favor of a national health plan, and you envisage that as a comprehensive program including



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3 on a Federal-Provincial basis and falling short of the
4 objective of a national health plan, and in fact you des-
5 cribe this second arrangment in paragraph 21 on page 6
6 as less desirable than a national programme. Dr. Baltzan
7 has been trying to ascertain from you what the differences
8 are between what you call a national health plan and a
9 Federal-Provincial plan. I wasn't quite clear what dif-
10 ference you have in mind, sir, bearing in mind the con-
11 stitutional division of responsibilities as it exists
12 in Canada.

12 MR. THIESSON: I think part of the difference
13 that we see, that there might be if a Federal-Provincial
14 plan was brought into effect is that the Federal Govern-
15 ment may lay down certain interim standards of health care
16 that would be provided in lieu of grants paid to the
17 provinces. In this case there may be certain provinces
18 that would accept this grant and provide the minimum
19 services. Others better financed would provide a higher
20 degree of service.

20 COMMISSIONER FIRESTONE: You have no objection
21 to that?

22 MR. THIESSON: We are saying that that would be
23 one of the weaknesses in it.

24 COMMISSIONER FIRESTONE: What is the difference
25 between what you call a Federal-Provincial programme and
26 what you call a national health plan?

26 MR. THIESSON: A national health plan would
27 provide a uniform programme of health care all across
28 Canada and people would be able to travel from one pro-
29 vince to another without losing privileges in terms of
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4 health care.

5 THE CHAIRMAN: To be nationally administered?

6 MR. THIESSON: Yes.

7 COMMISSIONER McCUTCHEON: It may be a uniformly
8 low programme?

9 MR. THIESSON: Yes, possibly.

10 COMMISSIONER McCUTCHEON: Would you prefer
11 that to a programme which had some high spots and some
12 low spots?

13 MR. THIESSON: Depending on where you live,
14 I expect.

15 COMMISSIONER FIRESTONE: If I may come back to
16 your description of a national health plan, in answer
17 to the chairman you described it as a nationally admini-
18 stered plan. You are familiar that under the consti-
19 tutional division of responsibilities the provinces
20 have a primary responsibility in the health field:
21 would you say you would expect the provinces to delegate
22 the right, authority, in the health field to the Federal
23 Government in order to administer a national health plan?

24 MR. THIESSON: Well, if there was a health
25 plan offered to the province that they felt was to their
26 advantage and to the general advantage of Canada, and
27 they felt like delegating this to the Federal authority
28 -- and I am sure it could be done --

29 COMMISSIONER FIRESTONE: Yes, I presume it
30 could be done, but you know how provinces are very con-
scious of their rights, and since the likelihood of such
delegation is not very great, would you consider a plan
as adequate and satisfactory whereby the Federal



health care.

THE CHAIRMAN: To be nationally administered?

MR. THIRSON: Yes.

COMMISSIONER MCCUTCHON: It may be a uniformly

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scious of their rights, and since the likelihood of such

delegation is not very great, would you consider a plan

as adequate and satisfactory whereby the Federal



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3 Government would make a financial contribution, set
4 certain standards and allow the provinces to administer
5 such a plan? Would you consider this adequate and
6 satisfactory?

7 MR. THIESSON: Temporarily adequate, possibly.

8 COMMISSIONER FIRESTONE: Would you explain to
9 us what you mean by "temporary"?

10 MR. THIESSON: We expect that if this comes to
11 pass that it would probably be operated in the way that
12 the hospital programme has been operated where it has
13 taken a number of years for all of the provinces to
14 participate in the hospital programme, and in this type
15 of programme there is going to be a varying degree of
16 hospital care given to people depending on the province
they live in.

17 COMMISSIONER FIRESTONE: Your concern, if I
18 understand you correctly, is that a plan exists in every
19 province operating on certain terms and standards set up:
20 your main concern is there should be a plan all across
21 Canada although there may be some variation in standards:
22 would such a system be satisfactory to your Association?

23 MR. THIESSON: I have answered that by saying
temporarily.

24 COMMISSIONER FIRESTONE: By "temporary" you
25 mean the objective would still be a change of the system,
26 and if that required constitutional amendment you would
be in favour of such constitutional amendment?

27 MR. THIESSON: As a long range objective.

28 COMMISSIONER FIRESTONE: But until such time
29 as this becomes possible and agreement is reached among
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Government would make a financial contribution, set certain standards and allow the provinces to administer such a plan? Would you consider this adequate and satisfactory?

COMMISSIONER FIRSTONE: Would you explain to me what you mean by "temporary"?

MR. THILSON: We expect that if this comes to pass that it would probably be operated in the way that the hospital programme has been operated where it has been a number of years for all of the provinces to participate in the hospital programme, and in this type of programme there is going to be a varying degree of hospital care of an in-patient depending on the province they live in.

COMMISSIONER FIRSTONE: Your concern, if I understand you correctly, is that a plan exists in every province operating on certain terms and standards set up. Your main concern is there should be a plan all across Canada although there may be some variation in standards. Would such a system be satisfactory to your Association?

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MR. THILSON: As a long range objective.

as this becomes possible and agreement is reached among



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3 the ten provinces, the other system would be adequate
4 and satisfactory?

5 MR. THIESSON: If there is a province pre-
6 pared to go ahead it should not be expected to wait
7 twenty years until all provinces could agree on a
8 programme.

9 COMMISSIONER FIRESTONE: You are then in
10 favour of a programme which would provide for the
11 Federal Government making a contribution and allowing
12 it to each province to administer it initially?

13 MR. THIESSON: That would have to be the way.
14 it would be done.

15 COMMISSIONER FIRESTONE: You have also estab-
16 lished in paragraph 14 on page 3 that you are in favour
17 of a compulsory prepaid medical care programme?

18 MR. THIESSON: That is right.

19 COMMISSIONER FIRESTONE: And you have set out
20 the reasons for it. Would you say that one of the
21 reasons you are in favour, one of the principles behind
22 it, is that you feel that to implement such a programme
23 you would want to implement the principle of the ability
24 to pay, and by including under a compulsory scheme
25 everybody in high and low income brackets you would make
26 it possible to make that principle of ability to pay
27 work?

28 MR. THIESSON: Yes.

29 COMMISSIONER FIRESTONE: Is this one of the
30 reasons why you are opposed or against a voluntary plan?

MR. THIESSON: Well, in a voluntary plan there
may be certain groups, for example, who do have the

the ten provinces, the other system would be adequate

MR. THOMPSON: If there is a province pre-
pared to go ahead it should not be expected to wait
twenty years until all provinces could agree on a

COMMISSIONER THOMPSON: You are then in
favor of a plan that would be a province for the
Federal Government to take over the situation and allowing
it to each province to make its own initiative?
MR. THOMPSON: I would have to be the way

it would be done

THOMPSON: I am in favor of a plan that you are in favor
of a compulsory program for all provinces?

MR. THOMPSON: That is right

COMMISSIONER THOMPSON: And you have set out

the reasons for it. Would you say that one of the
reasons you are in favor of the principles behind
it, is that you feel that to have such a programme
you would want to implement the principle of the ability
to pay, and by including that a compulsory scheme
everybody in the end for some benefits you would make
it possible to make that people or ability to pay

MR. THOMPSON: Yes

COMMISSIONER THOMPSON: Is this one of the

reasons why you are opposed to a voluntary plan?
MR. THOMPSON: Well, in a voluntary plan there
may be certain groups, for example, who do have the



1
2
3 ability to pay who may stay outside of it, and there
4 may be other groups who do not have the ability to pay
5 who may have to be supplemented by direct aid from the
6 province and this has its limiting factors.

7 COMMISSIONER FIRESTONE: I come now to another
8 subject altogether, if I may, and that is paragraph 35
9 in which you comment on the cost of drugs, and in para-
10 graph 36 you say, "We believe early Federal action is
11 required in more rigidly controlling the costs of drugs
12 to the consumer in Canada." Could you suggest to the
13 Commission how such a recommendation could be implemented?

14 MR. GLEAVE: One manner you might use would
15 be through the Restrictive Trade Practices Commission
16 as was done in some other matters. It has not proven
17 entirely effective, but this is one way we suggest. The
18 other thing, of course, failing this, they could attempt
19 to take the very drastic measure of simply setting the
20 price and saying, "You can only do so much and this is
21 it." That would be pretty drastic.

22 MR. THIESSON: I think in the Restrictive
23 Trade Practices Commission there was reference made to
24 the Patents Act, and that it wasn't really working out
25 the way it was intended to work, and it permitted manu-
26 facturers to copy, in effect, very nearly the ingredi-
27 ents of the medical drugs which had the same net effect,
28 and possibly a tightening of the Patents Act may be one
29 way of doing it.

30 COMMISSIONER FIRESTONE: Would you think the
Saskatchewan Farmers' Union would support the establish-
ment of a national drug council that would undertake



1
2
3 studies into the question as to why drug prices are high,
4 thus giving the public and governments the basic facts
5 on which policies can be formulated?

6 MR. GLEAVE: Yes, we would certainly support
7 any proposal which looked as though it could bring some
8 results in this field.

9 COMMISSIONER FIRESTONE: Are you familiar that
10 some of the hospitals in the Province of Saskatchewan
11 do not call for tenders in purchasing drugs?

12 MR. GLEAVE: No, I am not familiar with this.

13 COMMISSIONER FIRESTONE: Well, if we may sug-
14 gest to you this was the information given to us, and
15 assuming this is correct, would you feel that perhaps
16 representations could be made to the Provincial Government
17 to arrange or to instruct or to advise such hospitals to
18 institute the tender system in order to bring down the
19 cost to the lowest possible basis on the basis of com-
20 petitive bidding?

21 MR. GLEAVE: Well, I would say in an ordinary
22 business that deals with the public, yes it would be a
23 good procedure, but let me qualify this: I am in a field
24 I don't know very much about.

25 COMMISSIONER FIRESTONE: In other words, you
26 have only established the principles of bringing drug
27 costs down, but the Farmers' Union has no specific pro-
28 posals as they affect the situation in the province?
29 After all, you are interested in bringing drug prices
30 down in your own province, and I am wondering whether
making recommendations to us will solve the problem,
whether citizens of your province will not want to



1
2
3
4 consider ways and means that this can be achieved with-
5 in your own jurisdiction?

6 MR. GLEAVE: We could consider these things,
7 but when a situation such as this has been clearly
8 brought to the attention of governments that this is
9 the responsibility of government to protect its people
10 against these abuses, and I think these governments,
11 both Provincial and Federal, will be very lax if they
12 have to wait until an organization such as the Saskat-
13 chewan Farmers' Union says, "You can do it in this
14 fashion.", because they should not wait for this.

15 COMMISSIONER FIRESTONE: All I am suggesting
16 is that you have made suggestions to the Royal Commission
17 advising the Federal Government, and my question is,
18 are you also making similar suggestions to the Provincial
19 Government?

20 MR. GLEAVE: No, we have not.

21 MRS. TREW: Mr. Chairman and Mr. Commissioner,
22 I would like to say that in my opinion it would be almost
23 impossible for a province to do very much about it in
24 Canada. I think at least it is nationwide, because we
25 don't manufacture drugs in Saskatchewan.

26 COMMISSIONER FIRESTONE: My last question is
27 in Paragraph 40: you have recommended on page 9 a pre-
28 paid drug plan as part of your long-range health pro-
29 gramme. Would you be in favour, in view of the limited
30 resources, in view of priorities that have to be estab-
lished, of introducing such a plan on a stage by stage
basis, and if I understand the recommendations in para-
graph 40, this is what you have in mind?



MR. THIESSON: Yes.

MR. GLEAVE: Yes, we can go on a stage by stage basis.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Mr. Gleave, it is quite late, and, as I mentioned to you, the primary purpose of receiving a delegation is not to enter into debate with them, but to elicit their views and recommendations and not to try to convert them to any views they may wish to hold, and it is in that sense I mentioned it.

MR. THIESSON: I understand.

THE CHAIRMAN: We are grateful to you; we appreciate the fact we have kept you very late and that it has helped us in trying to get back on the rails insofar as catching up with our agenda is concerned for the rest of the week. Thank you very much.

MR. GLEAVE: We appreciate it, Mr. Chairman.

THE CHAIRMAN: Tomorrow we start at nine o'clock with a representation from the Saskatchewan Federation of Labour.

---ADJOURNMENT:

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

REGINA

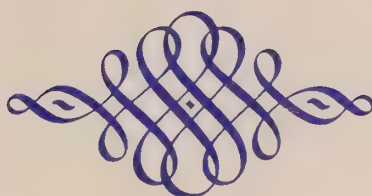
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1. THE SASKATCHEWAN PHARMACEUTICAL ASSOCIATION

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VOLUME 19

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held
at Regina, Saskatchewan,
January 24, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT H. HALL ----- Chairman

MISS ALICE GIRARD, R. N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q. C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q. C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



Regina, Saskatchewan,
Wednesday, 24, 1962.

----ON RESUMING AT 9:00 a. m.

ON SUBMISSION OF SASKATCHEWAN FEDERATION OF LABOUR

APPEARANCES:

Mr. W. E. Smishek - Executive-Secretary

Mr. I. E. Moore - Treasurer

THE CHAIRMAN: Gentlemen, if you are
ready to proceed.

THE SECRETARY: This brief will be
Exhibit No. 86.

---EXHIBIT No. 86: Submission of Saskatchewan
Federation of Labour.

MR. SMISHEK: Mr. Chairman and Members of
the Commission: firstly, I wish to apologize that some
of our people who were to accompany Mr. Moore and myself
this morning are not able to be here because of time
being re-scheduled. We were supposed to come on
yesterday at eleven o'clock in the morning and made
arrangements for our people to be here. However, as
the time was changed some of our people were called out
of town and others have meetings on this morning and
unfortunately we have a much smaller delegation than we
had expected.

I am the Executive-Secretary for the
Saskatchewan Federation of Labour and Mr. Moore is the
Treasurer.



1 Our Federation welcomes the establishment
2 of the Royal Commission on Health Services to look into
3 the personal health facilities throughout Canada
4 and to make recommendations on any improvements that
5 can be made in health services in the country. We
6 also welcome the opportunity of appearing before the
7 Commission. It is not always that Commissions of
8 this nature travel through the whole of the country.
9 We certainly appreciate this opportunity to be able to
10 present our views.

11 Our first submission points out at the out-
12 set, the Federation represents directly over 25,000
13 affiliated Unionists. We also feel that we can speak
14 for those Unions who today are not affiliated with the
15 Saskatchewan Federation of Labour and we know many of
16 the views we express in our submission are supported
17 by the unorganized workers. During the past years
18 our Federation has given much more study to the question
19 of health services than we had in previous years. We
20 are concerned about the health services in Canada and
21 we do hope that the views that we express in our sub-
22 mission will be taken into consideration carefully when
23 the report of your Commission is delivered to the
24 Government. Our Federation last year about this same
25 time presented a lengthy submission to the Advisory
26 Planning Committee on Medical Care in Saskatchewan.
27 We did attach that submission to our statement to your
28 Commission and we feel that the brief that we submitted
29 to the Advisory Planning Committee on medical care
30 elaborates more fully our views on health services.



of the Royal Commission on Health Services to look into
the personal health facilities throughout Canada
and to make recommendations on any improvements that
can be made in health services in the country. We
also welcome the opportunity of appearing before the
Commission. It is not always that Commissions of
this nature look through the whole of the country.
We are very grateful for the opportunity to be able to
present our views.

The first question put to the sub-
committee was the Federation represents directly over 25,000
affiliated hospitals. We also feel that we can speak
for those who are not affiliated with the
Canadian Hospital Federation of Ontario and we know many of
the views we express in our submission are supported
by the non-affiliated hospitals. During the past years
our Federation has given more and more weight to the question
of health services than we had in previous years. We
are concerned about the health services in Canada and
we do hope that the views that we express in our sub-
mission will be taken into consideration seriously when
the report of your Commission is delivered to the
Government. Our Federation has been about this same
time concerned in a very active way in the Advisory
Planning Committee on Health Care in Saskatchewan.
We are aware that attention to our statement to your
Commission and we feel that the belief that we submitted



1 In addition, our Federation last year
2 also presented a submission to the Aged and Long Term
3 Illness Survey Committee for the Province of
4 Saskatchewan. In that submission we also dealt with
5 the health needs as they pertain to long term illness.
6 We will be glad to provide the members of the Commission
7 with copies of that submission as well. There may be
8 items in there which might be of interest to you.

9 THE CHAIRMAN: It would be very good
10 if you would do that.

11 MR. SMISHEK: We have copies and we will
12 file them with the Secretary.

13 THE CHAIRMAN: The one you presented
14 to the Advisory Committee will be Exhibit 86A and the
15 other one Exhibit 86B.

16 ---EXHIBIT No. 86A: Submission of Saskatchewan
17 Federation of Labour to
18 Advisory Planning Committee
19 on Medical Care In Saskatchewan.

20 ---EXHIBIT No. 86B: Submission of Saskatchewan
21 Federation of Labour to
22 Long Term Illness Survey
23 Committee for the Province
24 of Saskatchewan.

25 MR. SMISHEK: Our Federation welcomes
26 the enactment of the Saskatchewan Medical Insurance Act
27 by the Province of Saskatchewan even though the present
28 Legislation does not meet all the proposals for a com-
29 prehensive service proposed by the Saskatchewan Federation
30 of Labour.

There is underway in our country an
insidious campaign telling the people that by extending



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the health needs as they pertain to long term illness.

We will be glad to provide the members of the Commission

with copies of that submission as well. There may be

items in there which might be of interest to you.

MR. CHAIRMAN: It would be very good

if you would do that.

MR. CHAIRMAN: We have copies and we will

file them with the Secretary.

MR. CHAIRMAN: The one you presented

to the Advisory Committee will be Exhibit B64 and the

other one Exhibit B65.

---EXHIBIT No. B64: Submission of Saskatchewan
Federation of Labour to
Advisory Planning Committee
on Medical Care in Saskatchewan.

---EXHIBIT No. B65: Submission of Saskatchewan
Federation of Labour to
Long Term Illness Survey
Committee for the Province
of Saskatchewan.

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the establishment of the Saskatchewan Medical Insurance Act

by the Province of Saskatchewan even though the present

Legislation does not meet all the proposals for a com-

prehensive service proposed by the Saskatchewan Federation

of Labour.

There is underway in our country a

intensive campaign telling the people that by extending



1 the public sector of our economy and by establishing the
2 public social security programs we are going to some-
3 way lose our present freedoms. High priced Executives
4 and publicity agents backed by large sums of money
5 dreaming up catch phrases with a view to impressing on
6 public minds that the people will lose their moral
7 fibre, whatever that means, we will lose our individualism,
8 we will surrender our freedoms to the State. Such
9 campaigns are false, immoral and mischievous. Members
10 of the Commission are now aware that the Trade Union
11 movement has been champions of freedom and especially
12 freedom of the individuals; we have fought equally as hard
13 for freedom from insecurity. We are convinced now
14 more than ever before, after studying the question of
15 health care in more detail for the past two years, that
16 only a public program can meet the needs of our people.
17 The fact is that when public programs of education,
18 hospitalization, workmen's compensation, old age pension,
19 mother's allowance and all other such programs were
20 legislated by our Governments, people gained some freedom.
21 No one would suggest that public education in Canada
22 should not be continued and that it has not been a great
23 factor in granting our people more freedom. No one
24 would suggest that the public hospitalization program
25 has not brought a measure of security; it has freed
26 the people from paying exorbitant hospital bills, relieved
27 payment of interest rates and prevented legal costs
28 and has freed the people from worry. We are equally
29 convinced a program of public health care will add to
30 the people's freedom from insecurity and fear.

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and publicly owned banks by large sums of money

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the people from paying exorbitant hospital bills, relieved

payment of interest rates and prevented legal costs

and has freed the people from worry. We are equally

convinced a program of public health care will add to

the people's freedom from insecurity and fear.



1 At page 3 of our submission we state ten
2 points of principles that our Federation believes should
3 be taken into consideration for a National health pro-
4 gram. Copies of this submission have been before the
5 Commission for several weeks and we do not feel it is
6 necessary to read these ten points of principle in which
7 we believe.

8 We have not in the submission to you
9 elaborated on some of those points because they are
10 covered in the brief to the Thompson Committee and all
11 we would be doing is repeating ourselves.

12 We in our Federation reject the proposals
13 that have been made to you that voluntary and non-profit
14 plans could meet the health needs of the Canadian people.
15 We also reject the proposition that through having them
16 subsidized that they would some way be more acceptable.
17 We feel that the voluntary programs have served a
18 purpose but they have not adequately met the health
19 needs of the people. All that subsidization of such
20 plans might do is reduce the price tag that the people
21 must pay but they can never achieve universal coverage
22 of which we are after. It is proven by experience that
23 subsidization will not achieve universal coverage. In
24 Australia such a plan has been in effect for almost
25 ten years and there are still almost 30% of the people
26 not covered.

27 THE CHAIRMAN: Thirty percent? The
28 figure I have had is 22%?

29 MR. SMISHEK: The figure I have is 28%
30 but I was rounding it out. I said "almost 30%." Our



information we have been
 in Federation believe should
 representation for a historical reality pro-
 gram. Copies of this information have been before the
 Commission for several weeks and we do not feel it is
 necessary to read these few points of principle in which

We have not in the submission to you
 distributed on some of these points because they are
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 subsidization will not achieve universal coverage. In
 Australia and a plan has been in effect for almost
 ten years and there still almost 30% of the people
 not covered.

figure I have had is 25%
 MR. SMITH: The figure I have is 18%



1 understanding is that in 1960 there was 72% or just about
2 that number covered. Now, in addition to that through
3 subsidization and voluntary plans there would still be
4 a great deal of duplication and money would be wasted
5 for administrative costs. The quality of care in our
6 opinion would not be improved.

7 Now, as the Members of the Commission
8 probably are aware, Canada is one of the last countries
9 without a public health program. In fact, Canada and
10 the United States are the two countries with their rich
11 resources that have today not seen fit to establish
12 public programs of health care. We recognize that
13 in other of the countries the programs are not in many
14 respects fully comprehensive. Nevertheless, many nations
15 whose resources are by far smaller than that of Canada
16 have seen fit to establish public health care programs.
17 We would, therefore, urge upon the Commission to give
18 careful consideration to the submission that we make and
19 if not in whole, at least in part make recommendations
20 to the Government of Canada along the lines we suggest.

21 With that brief introduction we would
22 be prepared to answer any questions that there may be
23 posed to us or attempt to answer them.

24 THE CHAIRMAN: Mr. Moore, have you any-
25 thing to add at the moment?

26 MR. MOORE: No, I have not.

27 THE CHAIRMAN: You are free, of course,
28 to expand and explain as you see fit.

29 Mr. Smishek, we are, of course, well aware
30 of your knowledge of this field because you were a member

understanding is that in 1960 there was 75% or just about
 that number covered. Now, in addition to that through
 subsidization and voluntary plans there would still be
 a great deal of duplication and money would be wasted
 for administrative costs. The quality of care in my
 opinion would not be improved.

Now, as the Members of the Commission
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to expand and explain as you see fit.

MR. SMILG: We are, of course, well aware

of your knowledge of this field because you were a member



1 of the Thompson Committee; that is a fact?

2 MR. SMISHEK: That is correct.

3 THE CHAIRMAN: And in your interim report
4 you have dissented from the idea of charging a premium
5 to any one. That was your position, was it not?

6 MR. SMISHEK: Yes sir. I did, sir, say
7 that the premiums are not -- direct premiums are not
8 the most desirable way of financing.

9 THE CHAIRMAN: Would you expand on that
10 because there is another view point, shall we say, that
11 we had from the Government yesterday that the College of
12 Physicians and Surgeons at least agree on that phase of
13 it that a premium was a desirable thing.

14 MR. SMISHEK: Well, I think our brief
15 to the Thompson Committee together with my dissenting views
16 fairly well expresses the position, my own position and
17 the Trade Union movement about how we feel about premiums.
18 Our primary reason for opposing the direct premium is
19 that it has no relationship or there is no relationship
20 to ability to pay. Premiums are normally flat premiums
21 as is now recommended by the Government for financing a
22 medical insurance program of \$12.00 for single persons
23 and \$24.00 for families. Now, whether a person earns an
24 income of \$1,000.00 a year or whether he has an income
25 of \$10,000.00 a year, the premium is the same. We feel
26 that is an unfair way of financing. We feel that a
27 health program should be financed in a way that will
28 have as much as possible relationship with ability
29 to pay. It has been suggested that those persons who
30 cannot pay that there would be some other municipal or



MR. SMITHERS: That is correct.

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of \$10,000.00 a year, the premium is the same. We feel

that is an unfair way of financing. We feel that a

health program should be financed in a way that will

have as much as possible relationship with ability

to pay. It has been suggested that those persons who

cannot pay that there would be some other municipal or



1 provincial government that would pay on their behalf.

2 THE CHAIRMAN: I understand from the
3 Honourable Mr. Davies that the group which is unable to
4 pay, the group that is in receipt of social aid, that
5 is the general classification, would not be required
6 to pay the premiums, so that group is eliminated to be-
7 gin with. Even with that elimination do you take the
8 position still that there ought to be no premium at all?

9 MR. SMISHEK: We recognize at a provincial
10 level where the Province has limited tax resources they
11 are quite often compelled to charge direct premiums.
12 However, our position is still that because the direct
13 premium has no relationship to the ability of people
14 to pay that it is not a fair tax basis because, as I
15 said, whether a persons earns or has an income of
16 \$1,000.00 or \$2,000.00 or whether the income is \$10,000.00
17 the premium is still the same.

18

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...the group which is liable to
pay the group that is in receipt of social aid, that
is the general classification, would not be required
to pay the premium, as that group is eliminated to be-
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level where the Province has limited the resources they
are quite often compelled to charge direct premiums.
However, our position is still that because the direct
premium has no relationship to the ability of people
to pay that is not a fair tax basis because, as I
said, who has a higher income or has an income of
\$1,000.00 or \$2,000.00 or whether the income is \$10,000.00
the premium is still the same.



1 THE CHAIRMAN: But if that was the only
2 system, but when you add that to the income tax proven,
3 do you not achieve that degree of equality of ability
4 to pay by the fact that the person with the \$10,000.00.
5 is paying an amount far in excess of what it would cost
6 to buy the coverage in the open market, coverage of the
7 broadest nature?

8 MR. SMISHEK: Well, we agree, remembering
9 this, Mr. Chairman, that at the time of my dissenting
10 views I had no knowledge as to what formula the Government
11 might introduce on financing the program. There were
12 proposals that were made to the council committees by
13 some groups that a larger share, or at least 50% of the
14 cost of the health program should be financed through
15 the direct premium and there were also suggestions that
16 the premiums should be equal to that now paid in respect
17 to hospitalization. Now, it is true that the tax
18 formula that has been devised by the Provincial Govern-
19 ment does to some degree relate to the ability to pay,
20 because of the income tax, because of the sales tax,
21 which also has some relationship to ability to pay,
22 because the people spend their money in different ways,
23 and pay on some luxurious items ---

24 THE CHAIRMAN: Everybody who pays sales
25 tax would be contributing ?

26 MR. SMISHEK: That is right, but by and
27 large our position is that the program should be financed
28 as much as possible---

29 THE CHAIRMAN: Let me put it this way.
30 You didn't know, you couldn't be expected to know at the



THE CHAIRMAN: But it that was the only

system, but when you add that to the income tax provision,

do you not achieve that degree of equality of ability

to pay by the fact that the person with the \$10,000.00,

is paying an amount far in excess of what it would cost

to pay the coverage in the open market, coverage of the

MR. SMITHWICK: Well, we agree, remembering

this, Mr. Chairman, that at the time of my own plan,

view I had no knowledge as to what formula the Government

might introduce in financing the program. There were

proposals that were made to the council committees by

some groups that a larger share, or at least 50% of the

cost of the health program should be financed through

the direct premium and there were also suggestions that

the premiums should be equal to that now paid in respect

to hospitalization. Now, it is true that the tax

formula that has been devised by the Provincial Govern-

ment does to some degree relate to the ability to pay,

because of the income tax, because of the sales tax,

which also has some relationship to ability to pay,

because the people spend their money in different ways,

and pay on some luxurious items ---

THE CHAIRMAN: Everybody who pays sales

tax would be contributing?

MR. SMITHWICK: That is right, but by and

large our position is that the program should be financed

as much as possible ---

THE CHAIRMAN: Let me put it this way.

You didn't know, you couldn't be expected to know at the



1 time of your dissent in the minority report, but you now
2 know, not you, I am talking about the Federation of
3 Labour, you now know what the formula is, and is your
4 position still that there ought not to be a premium?

5 MR. SMISHEK: Well, I think that the
6 answer is that we recognize that the Provincial Govern-
7 ment, with its limited tax resources, is pretty well
8 compelled to have a direct premium, but we feel that on
9 the national basis that a direct premium is undesirable.

10 THE CHAIRMAN: So you now approve of the
11 imposition of the premium under Saskatchewan Legislation?

12 MR. SMISHEK: On a temporary sort of a
13 basis, yes.

14 THE CHAIRMAN: Now, you advocate a
15 national scheme, I mean a national program. In doing
16 that, do you see that program being identical across the
17 ten Provinces?

18 MR. SMISHEK: We feel that it, inasmuch
19 as possible, should be a uniform program. There might
20 be, because of regional problems, that there might be
21 some variations, but by and large there should be a basic
22 sort of uniform program which provided for basic uniform
23 or minimum coverage.

24 THE CHAIRMAN: Could you give us some
25 concrete example of those variations that you think may
26 justify a variation in the program?

27 MR. SMISHEK: Well, taking in the question
28 of the visiting nursing care, there might be some.

29 THE CHAIRMAN: It would be in the details
30 of the program?



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1 MR. SMISHEK: That is right, in the
2 details of the program there might be some variations
3 to meet the needs of the people in the particular
4 province.

5 THE CHAIRMAN: Is it your view then
6 that the financing arrangements should be uniform through-
7 out the country?

8 MR. SMISHEK: Yes, certainly.

9 THE CHAIRMAN: And, accepting for the
10 moment that one could have a national program in Canada,
11 by whom, by what authority should that program be
12 administered? The Federal authority, or by the provinces?

13 MR. SMISHEK: Well, our proposal is
14 that really under the ten principles as we set out, is
15 that it should be administered by the Department of
16 Health, Federal, Provincial, and also on a local level.

17 THE CHAIRMAN: Well now, that is a troika
18 or something, but it would have to be some kind of a
19 master proposition. I mean to say, administration
20 would have to be an administrative head, in the sense of
21 an administrating body?

22 MR. SMISHEK: We feel that the Federal
23 Government should accept the basic responsibility and
24 sort of set national minimum standards and really in co-
25 operation with the Provincial Government there should
26 be a proper sort of administration procedure set up.

27 THE CHAIRMAN: Well, do you see the
28 provinces, any province in Canada, foregoing its
29 provincial rights' position to accept a junior position
30 under the Federal Department of Health?



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1 MR. SMISHEK: Well, I don't know that
2 this question has been really explored. I don't think
3 it is a question of accepting any junior position.
4 Certainly in Canada on certain matters the Federal or
5 National matters, the Federal Government accepts re-
6 sponsibility and that there are no objections from the
7 provinces. We recognize that at the present time
8 under our Constitution there are restrictions, and there
9 would be problems, but we think that those things could
10 be worked out.

11 THE CHAIRMAN: Well, are you not aware
12 that at least one of the provinces has already officially
13 taken the position that this Commission really should
14 not be in business, that it is wholly the responsibility
15 of the provinces to look after health needs, and health
16 services, and that the Federal Government has no business
17 in the field at all?

18 MR. SMISHEK: No, I am not aware. I
19 probably didn't read that. What province is that, if I
20 may ask?

21 THE CHAIRMAN: Well, that is the Province
22 of Quebec.

23 MR. SMISHEK: Well, there might be, if
24 there are some extreme difficulties that cannot be
25 worked out, certainly the program, it still is possible
26 to establish some minimum standards, we feel, to those
27 provinces which are prepared to accept the program in
28 a program of grants and aid similar to what we have in
29 the hospitalization field, but we feel that every effort
30 should be made to explore the possibilities of establishing



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should be made to explore the possibilities of establishing



1 a national health service.

2 THE CHAIRMAN: In this idea of accepting
3 that, again I mean to say on that basis, that you would
4 have a program which would have to be Provincially ad-
5 ministered with Federal assistance to those provinces
6 which are willing to accept Federal assistance, have
7 you a view to express as to whether that program should
8 be put into operation one province at a time, or should
9 we wait until we have a majority of the provinces and so
10 a majority of the people of Canada covered, before such
11 a program should be brought into operation?

12 MR. SMISHEK: Well Mr. Chairman, I think
13 we did state in our brief that when provinces extend
14 their programs in the health field that the Federal
15 Government should offer assistance.

16 THE CHAIRMAN: That is one by one?

17 MR. SMISHEK: Yes, our answer would be
18 as the Provincial Governments extend their programs
19 the Federal Government should offer assistance if this
20 is the way our health services are going to be extended
21 in this country, then certainly we would favour that
22 kind of thing.

23 THE CHAIRMAN: Then, do you advocate
24 then that the taxing power of the Federal authority,
25 which collects taxes from all provinces, should be used
26 to collect taxes from all provinces, and expend it
27 in this health service program in one province only?

28 MR. SMISHEK: Well, Mr. Chairman, this
29 might act as a catalyst, probably, in encouraging other
30 provinces to proceed in extending their health services.



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1 THE CHAIRMAN: Well, is it just shall
2 we say the desire to join the club, would that be a
3 sufficient reason for inaugurating a health services
4 program?

5 MR. SMISHEK: Well, as far as we are
6 concerned, that is not the reason we proposed it. We
7 feel that there is a need.

8 THE CHAIRMAN: No, but you say it would
9 be a catalyst. It would be the motivating force to
10 bring everybody in, so that they get their share of the
11 profit?

12 MR. SMISHEK: But we feel that there
13 is certainly a need throughout Canada of establishing
14 public health services. It might be that because of
15 pressures from certain areas, that some Governments
16 might be a little reluctant to extend their health ser-
17 vices, but in our judgment there is certainly a need,
18 and that the Federal Government should offer assistance
19 to every province that is prepared to extend their
20 health services.

21 THE CHAIRMAN: And without any minimum
22 conditions that it should be five provinces, or six,
23 or four, or any number of them?

24 MR. SMISHEK: Yes, without any minimum
25 conditions.

26 THE CHAIRMAN: Thank you, Mr. Smishek.

27 COMMISSIONER VAN WART: I just have one
28 question. On page 9, G, speaking about the voluntary
29 plans: "What is perhaps the most important objection to
30 private plans is that they are not concerned with the



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THE CHAIRMAN: Thank you, Mr. Smith.

COMMISSIONER VAN WART: I just have one

question. On page 9, G. speaking about the voluntary
plans: "What is perhaps the most important objection to
private plans is that they are not concerned with the



1 quality of medical care". Assuming that is true,
2 that infers that the plan you suggest would improve
3 the quality, the plan itself would improve the quality?

4 MR. SMISHEK: Yes, we do feel that through
5 better organization, co-ordination, quality will be
6 improved.

7 COMMISSIONER VAN WART: Would not the
8 same better organization in the voluntary plans improve
9 their quality by the same reason?

10 MR. SMISHEK: Well, there might be an
11 improvement made by the voluntary plans, and I think
12 that they have in some small measures have helped to
13 improve quality but really as far as our studies show
14 that only through a unified, co-ordinated public program
15 can we achieve the high quality of care that we do
16 mention in our brief, as pointed out by some authoritative
17 people in the field of health.

18 COMMISSIONER VAN WART: Well, availability
19 and quality are different. Your plan may make the
20 services more available, but not in itself improve the
21 quality. The quality comes from subordinated things,
22 really, to the plan does it not?

23 MR. SMISHEK: That is right, but re-
24 membering that what we in our proposals and vision,
25 that the whole health field would be examined and sort
26 of attacked in all directions, in the field of education,
27 in the field of research, and through the co-ordination
28 of such a program that you would achieve higher quality,
29 remembering that by and large the voluntary plans have
30 limited themselves to diagnostic and curative services.



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remembering that by and large the voluntary plans have

limited themselves to diagnostic and curative services.



1 COMMISSIONER VAN WART: Yes, I realize
2 that.

3 MR. SMISHEK: They have not entered the
4 field of research and the field of education. They
5 are very limited areas. Nursing care and rehabilitation,
6 these are areas with which the voluntary plans have not
7 concerned themselves, and these are all areas, which
8 help to improve the quality of care, and we think this
9 would come about through a public program.

10 COMMISSIONER VAN WART: Those things
11 could be brought about without either plan, could they
12 not?

13 MR. SMISHEK: Well, maybe they can. I
14 don't know. Maybe they can. Certainly it has not been
15 done now.

16 COMMISSIONER VAN WART: The mere
17 presence of the plan does not necessarily mean quality
18 improvements. That is the point I am making.

19 MR. SMISHEK: But we also feel the
20 organization of health services has a great deal to do
21 with quality.

22 COMMISSIONER VAN WART: I agree with that.
23 I agree with that, surely.

24 COMMISSIONER BALTZAN: You are aware
25 we are trying hard to make a thorough search and obtain
26 opinions and information from all reliable sources,
27 without pre-confused notions, as the Chairman has
28 stated originally, and certain independently. I am
29 very much disturbed with the result of the effects of
30 the national health service on physicians utilization and



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1 health in England and Wales, submitted by independent
2 neutral observers I would call them, the Chief, Division
3 of Public Health Methods, the Department of Health in
4 the U.S.A. Biometrics and social studies of
5 the Health Department in the U.S.A., and this is the
6 part that disturbs me. I had hoped to hear something
7 better: "There is no clear evidence say these two
8 authors that the increases in physician utilization,
9 by that we can take medical, nursing services, and the
10 whole gamut of things, there is no clear evidence
11 increased utilization of these services apparently
12 resulting from the national health services, that these
13 things have not improved the health of the adult popu-
14 lation, and thus they say it is not certain whether the
15 increased utilization in the area which I mentioned was
16 a reflection of an unmet health need, or was merely the
17 reflection of an unmet demand ". They have been in
18 operation since 1948, and some reflection on the health
19 of the population as a result of this comprehensive
20 system that they have, that that should be in evidence,
21 at least statistically, so I am personally disappointed,
22 and I would like to know what your reaction is?

23 MR. SMISHEK: Mr. Chairman, it seems,
24 as far as the national health service is concerned,
25 it depends who is writing at a particular time. There
26 are also articles and documents written, and statements
27 made by people that say the reverse. Now, we can
28 take even the numerous statements made by very prominent
29 health or medical people in Great Britain in which they
30 stated emphatically that health service has been a trem-
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 success-it has been a tremendous success in improving



the health of the people generally.

As far as the British national health service is concerned, it all depends whose article you read and whose views you want to accept.

COMMISSIONER BALTZAN: You are quite right and we have all read both sides of the story, but I submit this to you because I take it this is unbiased, presumably, and it is neutral in a sense, and it comes from observers in another country and it hasn't any relation to inner squabbles within the nation. That is why I say I am disturbed to see outsiders have that opinion. You submitted to us here a statement to the Advisory Planning Committee on Medical Care by the Saskatchewan Federation of Labour; I don't know what you call this, but it is appendix A, and then, on page 7, "A survey found that sickness benefits for insured persons under a public or a publically controlled program were in effect in the following countries ", and the dates are shown. I haven't counted them, but there are about 40, and they are listed. If I marked the oldest of these, and it says here:

Austria 1888

Belgium 1894

Bulgaria 1918

Czechoslovakia 1888

German East and West 1883,

and so on.

The comment here, because you submitted it --- you concur -- and I quote: "It will be seen from the foregoing that Canada and the United States remain in unsplendid isolation as the two riches countries

service is concerned. It all depends whose article you read and whose views you want to accept.

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it -- you know -- and I quote: "It will be seen

from the foregoing that Canada and the United States



1 in the world still without health insurance." Consider-
2 ing the bigger of these two nations and what they have
3 accomplished in the health field -- what you might call
4 retail rather than wholesale schemes -- I am just
5 wondering, and having a certain amount of pride in our
6 western way of doing things, whether one might be proud
7 to be not exactly in their company. Canada and the
8 U.S. have not been without sickness benefits and in-
9 surance of various kinds, although not necessarily
10 government sponsored. In other words, do you believe
11 that the health of this nation by virtue of the fact
12 they haven't got these things --- and of these I think
13 there are only two who have complete, comprehensive,
14 all inclusive service on the national scale; only two --
15 perhaps more, but I didn't go into a complete investi-
16 gation: my point is that because we haven't got in
17 the U.S.A. or Canada a comprehensive government sponsored
18 complete service, can we say that because of that the
19 health of the nation is in any way inferior to some of
20 these examples you put before us?

21 MR. SMISHEK: Well, it is difficult
22 to answer as to whether the health of the nation as a
23 whole is inferior to that of those countries we mentioned.
24 There are other factors we recognize that affect the
25 health of the people. But, certainly, we cannot say
26 that in this country when we study some of the reports
27 that are available that we can be particularly proud of
28 the health of our people. When we take a look at
29 the official history of the Canadian medical services
30 for army service between 1941 and 1944, when 740,000



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1 Canadian young men were either volunteered or called
2 into the Army, and it was found that 35.5% of them were
3 in a poor state of health, certainly we can't say we
4 have really a healthy nation. We feel that through
5 an organized health service we can make an improvement
6 in that field, but we are not prepared to say that be-
7 cause many of these nations have a nationalized program
8 that their health is that much better, because there
9 are other factors that affect it.

10 COMMISSIONER BALTZAN: How statistics
11 do mislead us, because by the same token, and one is
12 discouraged to read a report that of those attempting
13 to enter service 35% are excluded because of being what
14 you term substandard. On the contrary, I say to you
15 that those who made examinations like that might also
16 be given credit for the standards that we used here,
17 that we would not endanger our Armies unless we made
18 a very strict examination, and I hold with our Army
19 medical people and those responsible for the security
20 of a type of individuals entering, and they gave them a
21 pretty rigorous type of examination, perhaps even more
22 so than other countries that were suffering from lack
23 of supply for their armed services. These statistics
24 you can read both ways.

25 I want to finish with one other thing,
26 without trying to be critical, I am just trying to get
27 things straightened out and interpret the evidence from
28 wherever it comes. You refer to the definition of
29 health by the World Health Organization, and to refresh
30 your mind I will read it on page 5: "Health is a state



Canadian young men were either volunteered or called
into the Army, and it was found that 25% of them were
in a poor state of health, certainly we can't say we
have really a healthy nation. We feel that through
an organized health service we can make an improvement
in that field, but we are not prepared to say that be-
cause many of these nations have a nationalized program
that their health is that much better, because there
are other factors that affect it.

COMMISSIONER BATTAN. How statistics

do mislead us, because by the same token, and one is
discouraged to read a report about of those attempting
to enter service 25% are excluded because of being unfit
you term substandard. To the contrary, I say to you
that those who make examinations like that might also
be given credit for the standards that we used here
that we would not encourage our Armed forces we made
a very strict examination and I hold with our Army
medical people and those responsible for the security
of a type of individual is enlisted, and they gave them a
pretty rigorous type of examination, perhaps even more
so than other countries that were suffering from lack
of supply for their armed services. These statistics
you can read both ways.

I want to finish with one other thing,
without trying to be critical, I am just trying to get
things straightened out and interpret the evidence from
however it comes. You refer to the definition of
health by the World Health Organization, and to return



1 of complete physical, mental and social well being and
2 not merely the absence of disease or infirmity." My
3 point in this connection is first, that I perfectly
4 agree with it -- an excellent definition; but in the
5 disruption of health one must take into account more
6 than one just narrow point of view, and I would just
7 sort of call attention to and ask you whether this is
8 entirely within the field of medicine, medical nursing
9 team aegis responsibility, because three factors would
10 seem to enter into this matter of an imbalance in the
11 state of health: one, what one might say is the bio-
12 physical, and that is the structural disease and path-
13 ology and functional disturbances. Another one, perhaps
14 of equal importance, is the economic deficits, existing
15 among people who by their deprivations contribute to
16 and are conducive to ill health. So, it is not en-
17 tirely a biophysical thing. Then, I would say
18 that the third -- and I think it behooves us here also
19 to consider it -- is the sociological aspect; ill health
20 due to environmental factors causing physical, mental
21 and emotional strains that come within the terms of the
22 definition of health as defined by the World Health
23 Organization. So that our view must be enlarged to
24 incorporate at least three major factors in helping to
25 satisfy the definition here: am I right?

26 MR. SMISHEK: Yes, I would not argue
27 with you in that, Doctor, but as the World Health
28 Organization does state in its Constitution, Governments
29 have the responsibility for health and their people
30 which can be fulfilled only by the provision of adequate



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point in this connection is first, that I perfectly agree with it -- an excellent definition; but in the distribution of health one must take into account more than one just narrow point of view, and I would just sort of call attention to and ask you whether this is strictly within the field of medicine, medical nursing team social responsibility, because these factors would seem to enter into this matter of an imbalance in the state of health, one, what one might say is the physical, and that is the structural disease and path-

ology and functional disturbances. Another one, perhaps of equal importance, is the economic deficit, existing among certain groups of the population, and one is not entirely a physical thing. Then, I would say that the third -- and I bring in behavior as here also to consider it -- is the sociological aspect; all health

and emotional states that come within the terms of the definition of health as defined by the World Health Organization. So that our view must be enlarged to include at least three major factors in helping to satisfy the definition here; am I right?

MR. SMITH: Yes, I would not argue

with you in that. Doctor, but as the World Health Organization does state in its Constitution, Governments have the responsibility for health and their people which can be fulfilled only by the provision of adequate



1 health and social measures.

2 COMMISSIONER BALTZAN: Quite right,
3 and I wish it had been embodied -- that these two
4 paragraphs were embodied in one, so we could give an
5 enlargement to the meaning. Otherwise it is restricted
6 to one narrow scope of trying to deal with the problem
7 of health. I agree with that, and I would add on the
8 economic. Thank you for listening.

9 COMMISSIONER FIRESTONE: Mr. Smishek,
10 do I understand, sir, that the Saskatchewan Federation
11 of Labour supports fully the provincial medical care
12 plan as embodied in the Saskatchewan Medical Insurance
13 Act of 1961?

14 MR. SMISHEK: Yes, we support the Act.
15 We say it is not adequate. We think it is, in our
16 view, good as far as it has gone, but it should have gone
17 further.

18 COMMISSIONER FIRESTONE: In other words,
19 you feel this is a right step in the right direction
20 but you would hope your Government can go further?

21 MR. SMISHEK: That is right.

22 COMMISSIONER FIRESTONE: Mr. Smishek,
23 does your Association approve of some of the basic
24 features included in this Act and I am referring first
25 of all to the compulsory feature, that this is a
26 universal scheme covering everybody in the province
27 and that participation is compulsory -- as compulsory
28 as a State can make it?

29 MR. SMISHEK: Yes, we agree with the
30 proposition that the program should be universal and



Commissioner

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COMMISSIONER BALTAN: Quite right.

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Does your Association approve of some of the basic features included in this Act and I am referring first of all to the compulsory feature. That this is a universal scheme covering everybody in the province and that participation is compulsory -- is compulsory as a State can make it?

MR. SMITH: Yes, we agree with the

proposition that the program should be universal and



1 cover all people.

2 COMMISSIONER FIRESTONE: And you are in
3 favour of the compulsory feature?

4 MR. SMISHEK: Yes, we are.

5 COMMISSIONER FIRESTONE: You are also in
6 favour that to the best of the Provincial Government's
7 ability funds should be raised on the basis of the
8 principle of ability to pay?

9 MR. SMISHEK: Yes, we say that in our
10 brief, that the program should be financed as much as
11 possible on the ability to pay.

12 COMMISSIONER FIRESTONE: You are familiar
13 sir, with the fact that the Provincial Government has
14 suggested to this Commission that it should recommend
15 to the Federal Government the development of a national
16 medical care plan which should involve, among other
17 things, a contribution of 60% to the cost of the Pro-
18 vincial program: are you familiar with that?

19 MR. SMISHEK: Yes, I wasn't here during
20 all the hearings, but I was here during part of the
21 time.

22 COMMISSIONER FIRESTONE: But I take it
23 you are familiar with that recommendation?

24 MR. SMISHEK: Yes.

25 COMMISSIONER FIRESTONE: Would the
26 Saskatchewan Federation of Labour support this re-
27 commendation?

28 MR. SMISHEK: Our feeling is that, if
29 anything, it should be higher than 60%.

30 COMMISSIONER FIRESTONE: In other words,



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MR. SMITH: Our feeling is that, if

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1 you would support it and you would say that if
2 Saskatchewan can get more out of the Federal Government
3 than 60%, more power to them?

4 MR. SMISHEK: No, I don't think we
5 would place that kind of interpretation on it, if my
6 understanding of the question is correct. We say
7 the Federal Government has a responsibility in providing
8 health services. We are not saying that we just want
9 to gouge the Federal Government. This is not our view.
10 We say they have a responsibility.

11 COMMISSIONER FIRESTONE: You are saying
12 that the Federal Government has a responsibility and
13 you would expect that the Federal Government would
14 make a contribution. You are in favour of the request
15 of at least 60%. Would you, yourself, or your
16 Federation recommend a higher proportion and, if so,
17 what proportion?

18 MR. SMISHEK: We have, if you have read
19 our submission, stated that we feel that when the
20 provinces expand their health services, the Federal
21 Government should be prepared to assume at least two-
22 thirds of the financial responsibility.

23 COMMISSIONER FIRESTONE: In other words,
24 would you go along with the proposal of the Saskatchewan
25 Government with 60% being a minimum, but you would
26 prefer as a matter of right to the people in each
27 province that two-thirds would be a more appropriate
28 proportion?

29 MR. SMISHEK: That is correct. Our
30 reason for that is because we feel that through the



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prefer as a matter of right to the people in each

province that two-thirds would be a more appropriate

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MR. MILLER: That is correct. Our

reason for that is because we feel that through the



1 Federal basis there is a broader tax base, that you
2 can make the tax on a more equitable basis than on a
3 Provincial basis. The provinces are limited as far
4 as their taxation ability is concerned, and as well the
5 economies of provinces vary from one province to another.

6 COMMISSIONER FIRESTONE: Let us assume
7 the proposal that has been put forward by the Saskatchewan
8 Government were accepted as being part and parcel of
9 the national plan --- this is a purely hypothetical
10 question, but we must examine some of the fiscal
11 applications --- how would you expect the Federal
12 Government would raise the funds that are required to
13 pay for those contributions?

14 MR. SMISHEK: I think in our submission
15 on financing we say that the taxes, that the health
16 program should be financed from the consolidated revenue.
17 If new revenues are needed, then we feel the corporation
18 taxes and personal income tax are, in our judgment,
19 most related to ability to pay. There are other
20 tax sources. We also mention a tax source similar
21 to something like the unemployment insurance where the
22 employers are assessed, and the truth is that employers
23 in many areas have accepted some responsibility for
24 provision of health services to their employees,
25 probably in many areas where voluntary programs have
26 been negotiated or granted by the employers were accepted
27 grudgingly, but nevertheless they are here, and we feel
28 there is another possible source.

29 COMMISSIONER FIRESTONE: Your main two
30 sources, I take it, are corporation tax and personal



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 there is another possible source.

COMMISSIONER FIRESTONE: Your main two

sources, I take it, are corporation tax and personal



1 income tax?

2 MR. SMISHEK: That is correct.

3 COMMISSIONER FIRESTONE: We have no
4 precedent of the Federal Government contributing 60%
5 to health costs, but we have a precedent in the field
6 of hospital insurance where the contribution is
7 approximately 50 rather than 60% or two-thirds. What
8 I would like to do, with your permission, is to put
9 before you some of the fiscal implications of what
10 this really would involve in terms of additional income
11 taxes to be collected and corporation taxes to be
12 collected to pay for such a national program as is being
13 proposed now. May I put it to you in the form of
14 questions based on the most recent figures that I
15 have been able to obtain from a publication entitled
16 "The National Finances: An Analysis of Revenues and
17 Expenditures of the Government of Canada 1961 to 1962",
18 published by the Canadian Tax Foundation in October,
19 1961. I will not trouble you with a lot of detailed
20 figures, but just give you some of the highlights to
21 see whether this is the sort of thing that your
22 Federation has in mind.

1 23 Now, in presenting these questions to
24 you I have to offer to you and your colleagues an
25 apology because this is not a calculation prepared by
26 our research staff, it is prepared by a very tired
27 Commissioner who did it last night between eleven
28 o'clock and one o'clock this morning. Therefore, I
29 cannot take full guarantee for the absolute accuracy
30 for the figures to the last decimal point but they appear



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1 to be something of that order. We will be very happy
2 to stand corrected on matters, at least on the cal-
3 culations by work to be done by your research staff,
4 by the Canadian Labour Congress and by our own research
5 staff.

6 With this expression of humbleness
7 in asking the questions I will proceed. We have, first
8 of all, to start by asking ourselves what a national
9 medical care plan such as has been envisaged by the
10 Government of Saskatchewan would cost. Now, as we
11 recall, we have been advised that your program for
12 the first year, for the first full year, may cost
13 something like Twenty and a half million dollars
14 to \$21,000,000.00 covering over 900,000 thousand people
15 in Saskatchewan. This works out to an average
16 per capita figure of approximately \$22. per annum.
17 Now, assuming that the average for Canada is similar
18 to the average for Saskatchewan and this is, perhaps,
19 an heroic assumption because in some provinces the
20 average may be higher but in some it may be lower,
21 the average may be a little lower in Canada than \$22.00
22 and perhaps as high as \$25.00. However, in the absence
23 of such figures I am taking the Saskatchewan average
24 as the basis for an average estimate.

25 Since Canada's population is about
26 eighteen million people plus, \$22.00 per capita it
27 would mean a medical care plan universally applied to
28 Canada of the order of \$400,000,000. plus assuming
29 that all ten provinces were to be covered. Now, you
30 will recall that I suggested we proceed on the assumption

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of all, to start by asking ourselves what a national medical care plan would cost. Now, as we recall, we have been advised that your program for the first year, for the first full year, may cost something like Twenty and a half million dollars to \$21,000,000.00 covering over 200,000 thousand people in Saskatchewan. This works out to an average per capita figure of approximately \$22.00 per annum. Now, assuming that the average for Canada is similar to the average for Saskatchewan and this is, perhaps, an heroic assumption because in some provinces the average may be higher but in some it may be lower, the average may be a little lower in Canada than \$22.00 and perhaps as high as \$25.00. However, in the absence of such figures I am taking the Saskatchewan average as the basis for an average estimate.

Since Canada's population is about eighteen million people plus, \$22.00 per capita it would mean a medical care plan universally applied to Canada of the order of \$400,000,000.00 plus assuming that all ten provinces were to be covered. Now, you will recall that I suggested we proceed on the assumption



1 that perhaps it is a bit more realistic than the 60%
2 or the two-thirds proportion which you suggested.
3 You use the 50% contribution by the Federal Government
4 simply because it is approximately the percentage which
5 is already being paid on the health insurance. Now,
6 this would involve a requirement for the Federal
7 Government to find \$200,000,000.00, at least
8 \$200,000,000.00 for the first year of the plan and
9 that amount will increase, of course, as the years
10 proceed. Now, to collect \$200,000,000.00, the money
11 will have to come from somewhere. Now, if all these
12 funds were collected through income tax - I am not
13 suggesting that you are recommending it, but just to
14 put the range of possibilities before you, if all these
15 funds would be collected through income tax, income
16 tax collections in Canada 1.6 million dollars and to
17 provide an extra \$200,000,000.00 in income tax would
18 mean an increase in taxation rates to yield an
19 additional 12-1/2% of the total income tax take. In
20 other words, a taxpayer who is now paying income tax
21 of \$100. would pay income tax of \$112.50. Now, if
22 we take a married person with two dependents, such
23 a family paid, with an income of \$5,000.00, such a
24 family paid \$318.00 in income tax in 1961. In other
25 words an extra 12-1/2% of the income tax payable by
26 the family would add \$50.00 to his income tax bill.
27 I take it from what you have said earlier that you would
28 find this a hardship on the average family and that you
29 would prefer to split the burden between the income tax-
30 payer and the corporation taxpayer. Am I right in that



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tax collections in Canada I estimate at \$1.5 billion and to
provide an extra \$200,000,000.00 in income tax would
mean an increase in taxation rates a yield an
additional 12-15% of the total income tax take. In
other words, a taxpayer who is now paying income tax
of \$100, would pay income tax of \$115.50. Now, if
we take a married person with two dependents, such
a family paid, with an income of \$2,000.00, such a
family paid \$338.00 in income tax in 1957. In other
words an extra 12-15% of the income tax payable by
the family would add \$50.00 to his income tax bill.
I take it from what you have said earlier that you would
find this a hardship on the average family and that you
would prefer to split the burden between the income tax
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1 understanding?

2 Now that you realize it would cost a
3 family of \$5,000.00 an extra \$50.00 a year in income
4 tax and a good deal more, of course, the higher your
5 income tax liabilities are.

6 MR. SMISHEK: Well, sir, we have not
7 suggested that income tax be the only source. Our
8 first proposition is that such a program be financed
9 through the consolidated revenue. In my own case,
10 I am not an economist and not in any way an expert
11 in the tax field but I can say this, that it would be
12 easier or probably more equitable, let us say, a person
13 paying an extra \$50.00 to get insurance for personal
14 income of \$5,000.00 than any direct charge that a
15 person with the same family who is earning \$2,000.00
16 and has to pay direct premiums, there is still some
17 equitability. I think that there are people who can
18 establish an equitable basis of taxation.

19 I am not an economist, we do not think
20 that, say, a figure of \$400,000.00 to provide health
21 services or what you have described as similar to the
22 Saskatchewan medical insurance envisages a comprehensive
23 enough program. It might cost more. Certainly
24 the program we propose might be running considerably
25 more and we recognize that but we think the health
26 of the people is that important that we can find ways
27 and means of financing it.

28 Certainly, as an example, we feel that
29 armament is an important matter for this country. We
30 raise one billion and three-quarter million dollars to



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raise one billion and three-quarter million dollars to



1 finance our armament program which, in many cases, before
2 some of the tools of war are made they become obsolete.
3 You mentioned the figure of \$400,000.00 if my memory
4 serves me right.

5 COMMISSIONER FIRESTONE: Four and a half
6 million dollars.

7 MR. SMISHEK: We spent that on the
8 Arrow Aeroplane which never got off the ground. Now,
9 surely the health for the people is of such importance
10 that we should be able to devise a tax system and
11 finance this in the same way as other important emergency
12 programs or programs of national interests are
13 financed.

14 COMMISSIONER FIRESTONE: If I under-
15 stand you correctly, you would feel that your Federation
16 would support an increase in income tax say to the
17 extent of 12-1/2% on income tax payable presently and
18 that in the example which I have offered you of a
19 married couple with two children, you would be in favour
20 of this family paying an extra \$50.00 a year in income
21 tax to contribute its share to the financial require-
22 ments.

23 MR. SMISHEK: A good percentage of our
24 people are now paying towards it, in one form or
25 another in the Province of Saskatchewan, a family
26 that wishes to enroll in a voluntary plan will be
27 paying at least \$84.00. It is not looking for new
28 money, it is averaging the money that is now being
29 paid into a different stream through a Government
30 sponsored program. So the fact is that family would



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Smithell

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1 very likely be paying less for health services than
2 it is now paying.

3 COMMISSIONER FIRESTONE: You are a very
4 good labour man and I think your brief is very well
5 put together, but your arithmetic does not quite stand
6 up because the man would also have to pay his 50%
7 under the Provincial arrangement and if the Federal
8 share is only 50% the other 50% would have to be raised
9 in the province. He might have to pay another \$50.00
10 in one way or another through a Provincial system.
11 It may work out to \$100.00.

12 I think the basic point which you are
13 making, and I do not want to get involved in the question
14 of whether the man will pay a little less or a little
15 more because in some groups he will pay more and in
16 some groups he will pay less, but we are only interested
17 in the principle. I take it from what you say that
18 you see no inherent opposition to increases in income
19 tax at the Federal level to pay for such a scheme
20 and if this involved \$50.00 a year the best thing the
21 experts can work out, you would be in favour of it.

22 MR. SMISHEK: The working people in
23 this country has never refused or failed to accept
24 their responsibility in paying taxes and the fact is
25 they are the biggest tax contributors to finance
26 not only this type of program but all the programs
27 administered by governments.

28 COMMISSIONER FIRESTONE: You are quite
29 right, this is a fact. All we are trying to find
30 out is whether the Saskatchewan Federation of Labour is



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making, and I do not want to get involved in the question

of whether the man will pay a little less or a little

more because in some groups he will pay more and in

some groups he will pay less. But we are only interested

in the principle. I take it from what you say that

you see no inherent opposition to increases in income

tax at the Federal level to pay for such a scheme

and if this involved \$50.00 a year the best thing the

experts can work out, you would be in favour of it.

MR. SMISHEK: The working people in

this country has never refused or failed to accept

their responsibility to paying taxes and the fact is

they are the biggest tax contributors to finance

not only this type of program but all the programs

administered by governments.

right, this is a fact. All we are trying to find

out is whether the Saskatchewan Federation of Labour is



1 in favour of that.

2 MR. SMISHEK: Yes.

3 COMMISSIONER FIRESTONE: You suggested
4 earlier that perhaps a more equitable system would
5 be to collect some from income tax and some from
6 corporation tax. I think this is probably a more
7 equitable system that the experts that you may want
8 to consult will confirm. What I have done as a
9 second stage, I have worked through your second pro-
10 posal of a more equitable distribution and I have
11 assumed that only half of the amount of the \$200,000,000
12 would be collected from income tax and another half
13 from corporation tax in line with your own thinking.
14 Now, what would this involve? It would involve that
15 income tax would be raised by \$6.25 per \$100. That
16 is income tax paid by the family with two children
17 which I have mentioned before with a \$5,000. income
18 would pay an extra \$25.00 on Federal income tax in
19 addition to the \$318.00 which they have been paying
20 previously under the 1961 Income Tax Rate Schedule.

21 Now, as far as the corporation tax is
22 concerned the Federal Government would have to collect
23 \$100,000,000. from corporation taxes. Now, the
24 corporation tax take of the Federal Government is 1.3
25 billion dollars, the last figure that was collected.
26 To collect \$100,000,000. from corporation tax requires
27 an increase of about 7-1/2% on corporation taxes paid.
28 That means that each corporation would have to pay an
29 additional \$7.50 for every \$100. they are now paying,
30 or to put it differently the corporation tax rate for



in favour of that.

MR. SMITH: Yes.

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1 incomes on corporations of over \$35,000. might have
2 to be raised from the 1961 level of 50% to close to
3 53%, an increase of close to three percentage points.
4 For corporations with income of less than \$35,000.
5 it would have to be raised by 3% from 21% to 24%.

6 Now, the point has been made to the
7 Canadian Government by Canadian business that cor-
8 poration taxes are already too high and they would
9 feel that if there are increases in corporation taxes
10 it would pass the burden onto business, would reduce
11 incentives, would make it more difficult for them
12 to be competitive in cases where they tried to pass
13 on increase of taxation with higher prices. Would
14 you feel that such an increase of three percentage
15 points on our income tax to pay a Federal share
16 of the universal medical plan would be reasonable and
17 would you feel that your Saskatchewan Federation of
18 Labour would recommend such an increase in corporation
19 taxes?

20 MR. SMISHEK: We did not specify
21 in our submission that any tax for financing of a
22 health program should be 50% paid by corporations and
23 50% through income tax or personal income tax as
24 there might be some variations. We do not feel
25 that the calculation that you make of three percent
26 increase in corporation tax would be exorbitant. We
27 think the corporations can assume that and probably
28 that the price is always passed on to the consumers
29 in the final analysis, therefore, there would be an
30 immediate outcry from business that it is putting them

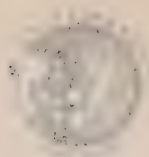


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increase in corporation tax would be excessive. We
think the corporations can assume that and probably
that the price is always passed on to the consumer
in the final analysis, therefore, there would be an
immediate outcry from business that it is putting them



1 in a more competitive business. We have heard this
2 many times. The fact is in other countries where
3 they have public programs, industry does assume the
4 responsibility and industry is taxed to help finance
5 the program in the health field. If it is 3%
6 that is necessary then we would accept that; if it
7 is higher or if it is less we do not know the exact
8 formula. As I said I am not an economist, I have
9 not worked the details. I am sure the Canadian
10 Labour Congress is going to be presenting his submission
11 to the Commission and we do have a staff of economists
12 working for the Canadian Labour Congress and they
13 might be able to give you a more exacting proposition
14 on specific tax that might be raised. You are
15 probably aware that the Canadian Labour Congress has
16 from time to time proposed more equitable bases of
17 taxation.

18 COMMISSIONER FIRESTONE: In fact, Mr.
19 Smishek, I have reserved these questions on the fiscal
20 application of such a plan that has been proposed by
21 other Unions until I came to Saskatchewan because we
22 would have the opportunity of asking you who are
23 rather knowledgeable on the subject. Since you mention
24 that the further work in this field will be done
25 by a parent organization I hope you will pass on
26 the sort of questions that have been asked to your
27 parent organization and give them an opportunity to
28 put their experts to work to offer the best possible
29 advice when they are going to submit their submission.
30 I will be very grateful to you.



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1 MR. SMISHEK: I will make it a point
2 to write to our people and advise them of what they
3 can expect. I think these are important areas
4 of questions to be answered.

5 COMMISSIONER FIRESTONE: Well now,
6 if I might continue with the application of what we
7 are discussing to the Saskatchewan situation rather than
8 to the national situation. You are quite right, Mr.
9 Smishek, he has not suggested that the split between
10 corporation taxes and income taxes should be necessarily
11 50%. We are here not so much concerned as suggested
12 at the beginning with the program, we are interested
13 in the principal and what the Saskatchewan Federation
14 feels would be an equitable approach to paying for
15 such a program. If I understood you correctly, if
16 an equitable arrangement would be a three percent
17 increase in the corporation tax rate, would you con-
18 sider this a reasonable sort of thing for a Canadian
19 corporation to pay to finance the scheme?

20 MR. SMISHEK: I should add that
21 \$400,000.00 --

22 COMMISSIONER FIRESTONE: \$400,000,000.00

23 MR. SMISHEK: Pardon me, \$400,000,000.00
24 for the industry to assume one hundred million dollars
25 and the 50%, I think if a calculation was made
26 throughout Canada, industry is very likely now paying
27 towards the voluntary programs or the commercial pro-
28 grams that amount or probably more. This is not
29 really new money that industry would have to find in
30 many respects.



MR. SMITH: I will make it a point

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grams that amount or probably more. This is not
really new money that industry would have to find in

many respects.



1 COMMISSIONER FIRESTONE: It is quite
2 obvious and you may want to pass this on to the
3 Canadian Labour Congress so they can consider this
4 sort of argument to present to the Commission.

5 THE CHAIRMAN: Since you are talking
6 about Saskatchewan and industry is not going to be
7 able to pocket that money and have to hand it over
8 to the groups under the Act, you say that is the problem
9 with the Act, is it not?

10 MR. SMISHEK: Yes, Section 31 says
11 that any contributions that have been made on behalf
12 of the employees previously, then they should be paid
13 to the employees.

14 THE CHAIRMAN: Therefore there would
15 be no saving to the corporations in that regard?

16 MR. SMISHEK: That is possibly ---

17 THE CHAIRMAN: It is more than
18 possibly. If they are going to have to take it out
19 of their fund, and pay it to an employee, how are
20 they going to have it left?

21 MR. SMISHEK: Well, that is correct.
22 In this respect, under Section 31, the employer has to
23 pay to the people, and here again, sir, it is I
24 suggest ---

25 THE CHAIRMAN: I am not talking about
26 the justice or injustice of it. You just said they
27 would have this extra money for themselves, they would
28 save money by the deal?

29 MR. SMISHEK: I was answering the
30 question in respect of a national level, and as far



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that any contributions that have been made on behalf
of the employer previously, when they should be paid
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of their fund, and pay it to an employee, but are
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pay to the people, and here again, sir, it is I
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would have this extra money for themselves, they would
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MR. SMITH: I was answering the

question in respect of a national level, and as far



1 as the Provincial level, that is correct, the employer,
2 under Section 31 of the Act, has to pay back to the
3 people.

4 COMMISSIONER FIRESTONE: If I may come
5 back to an answer which you gave earlier. If I under-
6 stood you correctly, sir, you look at the arrangement
7 of paying for the Saskatchewan plan in part through
8 premium as a temporary arrangement, and you would
9 hope that as a result of improved methods of paying
10 that in due course the premium arrangement might be
11 dropped. Did I understand you correctly?

12 MR. SMISHEK: Yes sir.

13 COMMISSIONER FIRESTONE: Would you
14 feel that when the time came, when the Federal Govern-
15 ment would make say a 50% contribution to a Saskatchewan
16 plan, that that might be the time for the Saskatchewan
17 Government to consider dropping the premium plan, if its
18 financial position so permitted?

19 MR. SMISHEK: Yes, we think that that
20 might be the time to look at it.

21 COMMISSIONER FIRESTONE: Let us assume
22 that the Federal Government does contribute the 50%,
23 and the Saskatchewan Government would contribute the
24 premium payment. Would you then be in favour that the
25 Saskatchewan Government continues to collect its own
26 50% of the cost of the plan through (a) income tax,
27 and (b) sales tax?

28 MR. SMISHEK: No, we still feel that
29 a national basis is a preferred basis. We still feel
30 that a national basis of taxation is better, sir, rather



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COMMISSIONER FIRSTSTONE: If I may come
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MR. SMITH: Yes, we think that that

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COMMISSIONER FIRSTSTONE: Let us assume
that the Federal Government does contribute the \$50,
and the Saskatchewan Government would contribute the
balance. Would you then be in favour that the
Saskatchewan Government continue to collect its own
50% of the cost of the plan through (a) income tax,
and (b) sales tax?

MR. SMITH: No, we still feel that

a national basis is a preferred basis. We still feel
that a national basis of taxation is better, sir, rather



1 than --- we are aware that there are new arrangements
2 for taxation to give the Province authority to tax,
3 but we really do feel that really a national pool should
4 be used, because we do have provinces, remembering
5 that any, say, income taxes from a particular province
6 might not be adequate, because of the economic conditions
7 of a particular province, and here I have at the moment
8 in mind the Maritimes, the Prairie Provinces. Remember-
9 ing, too, that much of the manufacturing of our
10 country, and two of the richest Provinces are British
11 Columbia and I think Ontario, and we think that the
12 national pooling arrangement is a better arrangement.

13 COMMISSIONER FIRESTONE: Well, sir,
14 this is an interesting statement of broad Federal -
15 Provincial fiscal relations. May I bring the question
16 back to the most specific question as to the manner
17 in which the Saskatchewan Government would be paying
18 its own share? It is paying for the program at the
19 moment as proposed, 100% of provincial sources of
20 financing. Now, under the plan where the Federal
21 Government would contribute 50%, the fact would still
22 remain that the Province of Saskatchewan would have to
23 raise the other 50%. This is how a sharing scheme
24 works out, doesn't it?

25 MR. SMISHEK: You use the figure 50%
26 each. Our proposition is that the Federal Government
27 should assume the major share.

28 COMMISSIONER FIRESTONE: You have made
29 the point, and I have accepted it, but just in a
30 realistic manner, and I take 50% as realistic because



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2
3 but we really do feel that really a national pool should
4 be used, because we do have provinces, remembering
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9 ing, too, that one of the manufacturing of our
10 country, and two of the richest provinces are British
11 Columbia and I think British, and we think that the
12 national pooling arrangement is a better arrangement,
13 COMMISSIONER TIRRELL: Well, sir,
14 this is an interesting statement of broad ideas,
15 Provincial financial relations. May I bring the question
16 back to the more specific question as to the manner
17 in which the Government would be paying
18 its own share? Is it paying for the program at the
19 moment as proposed, kind of provincial sources of
20 funds and, now, under the plan where the Federal
21 Government would contribute 70% the fact would still
22 remain that the Province of Saskatchewan would have to
23 raise the other 30%. This is not a sharing scheme
24 worse off, doesn't it?
25 MR. TIRRELL: You use the figure 50%
26 60%. Our proposition is that the Federal Government
27 should assume the major share.
28 COMMISSIONER TIRRELL: You have made
29 the point, and I have accepted it, but just in a
30 realistic manner, and I take 50% as realistic because



1 we have a precedent, maybe a higher percentage can be
2 worked out, but just for consideration on this basis,
3 and on the basis that we have it already operating in
4 Canada on another health field, I would like to pursue
5 a discussion on what I consider a realistic basis. Would
6 you say that the 50% which the Saskatchewan Government
7 would have to obtain from the people of Saskatchewan
8 should be, once the premium is dropped, be obtained
9 through the other two sources of revenue which are pre-
10 sently enforced, which are income tax and sales tax?

11 MR. SMISHEK: Well, we also sir feel
12 that there are some regressive features in sales tax
13 structures. Unless you have a sales tax so devised
14 which excludes sort of all the necessities of life.
15 Now, I think I said that Provincial Governments do have
16 limited sources of resources, and this is why we stress
17 the point of the Federal Government assuming the major
18 share of responsibility, but we do agree that income
19 tax does have the most equitable basis for taxation.
20 Now, there probably might be a point where you can sort
21 of over-tax on the income basis, and other methods might
22 be needed. Generally, I would say that the other two
23 sources would be income tax or other sources, income
24 tax, corporation tax, and sales tax would be probably
25 the sources of revenue that the Provincial Government
26 could look forward to, but also devising the sales tax
27 structure so as to exclude paying a tax for all the
28 sort of, many of the necessities of life.

29 COMMISSIONER FIRESTONE: The
30 Saskatchewan Government has proposed, has in fact in



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2 worked out, but just for consideration on this basis
3 and on the basis that we have it already operating in
4 Canada on another basis. I would like to pursue
5 a discussion on what I consider a realistic basis. Would
6 you say that the 50% which the Saskatchewan Government
7 would have to obtain from the people of Saskatchewan
8 should be, once the premium is dropped, be obtained
9 through the other two sources of revenue which are pre-
10 scribed in the Act, which are income tax and sales tax?
11 MR. STONEHOUSE: Well, we also are not
12 that there are some negative factors in sales tax
13 structure. Unless you have a sales tax so revised
14 which excludes a sort of 25% the necessities of life.
15 Now, I think I would like to know if the Government do have
16 limited sources of revenue, and this is why we stress
17 the point of the Federal Government assuming the major
18 share of responsibility, and we do stress that income
19 tax does have the most equitable basis for taxation.
20 Now, there probably might be a point where you can sort
21 of over-tax on the income basis, and other methods might
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23 sources would be income tax and other sources, income
24 tax, corporation tax, and sales tax would be probably
25 the sources of revenue that the Provincial Government
26 could look forward to, but also devolving the sales tax
27 structure so as to exclude paying a tax for all the
28 sort of, many of the necessities of life.



1 operation, a sales tax of 5% as of January the 1st, 1962,
2 and my question is very simple. Would you be in favour
3 after a Federal contribution has been made which is 50%
4 or larger as you propose, that the balance will still
5 be collected by the Provincial Government on the basis
6 it is collecting it now in the field of income tax and
7 sales tax, having abandoned the previous payment
8 which you consider inequitable?

9 MR. SMISHEK: I wouldn't like to
10 commit ourselves on any long term basis. We would
11 like to take a look at the time that moneys are forth
12 coming from the Federal Government, and at that
13 particular time see what would be our view of the best
14 way the Provincial Government should raise the money.

15 COMMISSIONER FIRESTONE: You are quite
16 right, sir. No wise person in politics or the labour
17 movement wants to commit himself forever, or a very long
18 term. You want to have a flexible approach, but in
19 principle, would you agree that the methods for financing
20 the program which the Saskatchewan Government is now
21 employing would be principles that you would be prepared
22 to support in the future, without necessarily saying
23 it should be so much income tax, so much sales tax,
24 whether this particular item should be exempt from sales
25 tax. I can see that you would wish to adjust them,
26 and develop a new attitude, but in principle you would
27 still be in favour of the Saskatchewan Government
28 financing the program out of income tax and sales tax?

29 MR. SMISHEK: Really what we did
30 specifically propose in our submission to the Thompson



operation, a sales tax of 2% as of January the 1st, 1965,
and my question is very simple. Would you be in favour
after a Federal contribution has been made which is 50%
or larger as you propose, that the balance will still
be collected by the Provincial Government on the basis
it is collecting it now in the field of income tax and
sales tax, having abandoned the previous payment
which you consider inadvisable?
MR. SMITH: I wouldn't like to
commit ourselves on any long term basis. We would
like to take a look at the time when money are forth
coming from the Federal Government, and at that
particular time see what would be our view of the best
way the Provincial Government should raise the money.
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1 Committee, sir, is really that consolidated revenue of
2 the Province be used, which includes many different
3 sources of taxes.

4 COMMISSIONER FIRESTONE: But I take it
5 you would have, there would be no change in your attitude
6 that sales tax, a portion of which is devoted to paying
7 for a medical care plan, should continue to exist, or
8 would you prefer at that time, or at a later stage, to
9 do with the sales tax what you have recommended for the
10 premium payment, of abandoning the collection of payments
11 for the medical care plan through sales tax. It is
12 as simple as that, just a question of the principle?

13 MR. SMISHEK: Really as far as we are
14 concerned we feel it would be desirable if new sources
15 of taxation were to remove the sales tax principle.

16 COMMISSIONER FIRESTONE: In other words,
17 you feel that if this could be collected say through
18 income tax, that you would prefer to have the Saskatchewan
19 Government rely on income tax, rather than on premium
20 and sales tax?

21 MR. SMISHEK: And consolidated revenue.
22 We feel that sales taxes do have some regressive features
23 in it, and as at the present time what has been proposed
24 for financing the plan generally we accept the proposition
25 at this time.

26 COMMISSIONER FIRESTONE: You realize,
27 sir, that if it is necessary to pay for a Saskatchewan
28 family to pay all of it out of income tax, it might in-
29 volve, as I said earlier, a payment of say \$50.00 to pay
30 the share of the provincial contribution, so that a family



Committee, sir, is really that consolidated revenue of
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that sales tax, a portion of which is devoted to paying
for a medical care plan, should continue to exist, or
would you prefer at that time, or at a later stage, to
do with the sales tax what you have recommended for the
payment of interest, of amortization, the collection of payments
for the medical care plan proposed sales tax. It is
as simple as that, just a question of the principle?
Really as far as we are

concerned we feel it would be desirable to have sources
of taxation used to finance the sales tax plan.
I am not sure if that is correct. It is not wrong
to feel that if the Government is interested any through
in the tax, that you would prefer to have the Government
Government rely on income tax, rather than on property
and sales tax.

And we would like to have some representative
to the fact that, as at the present time what has been proposed
for financing the plan generally we accept the proposition
at this time.

And, that if it is necessary to pay for a Government
family to pay all of the cost of income tax, it might in-
volve as I said earlier a payment of \$100.00 to the



1 of \$5,000. with two children, may find itself in the
2 position of having to pay \$50.00 extra in taxes to the
3 Federal Government, and \$50.00 to the Provincial Govern-
4 ment, a total of \$100.00. Now, as I said at the beginning,
5 I hold no brief for the figures. They could be higher,
6 they could be lower, and we leave it to the experts,
7 yourselves and ourselves, to work it out. Assuming
8 the experts said these are the figures, the program
9 would involve, increase in income tax to the extent of
10 \$100. a year for the average family to two children,
11 having an average income of \$5,000.00, and correspondingly
12 higher amounts for people in higher income brackets.

13 MR. SMISHEK: We have said that, we
14 have said that income tax is the most fair basis at the
15 present time.

16 COMMISSIONER FIRESTONE: So the
17 answer to my question is?

18 MR. SMISHEK: Generally speaking,
19 yes.

20 COMMISSIONER FIRESTONE: Thank you
21 very much. Now, may I turn to another question. On
22 page 4 of your submission, in paragraph (h) you have
23 recommended "that the medical plan should be administered
24 by the Departments of Health at Federal, Provincial
25 and Local levels", and in paragraph 13 of your dissenting
26 views, sir, on page 170 of the Interim Report of the
27 Advisory Planning Committee on Medical Care, you said,
28 if I may quote: "I wish to go on record as opposing
29 any form of Commission organization", and I am just
30 quoting this paragraph in support of what you say in



higher, may find itself in the

...ing to pay \$50.00 more in taxes to the

Federal Government, and \$50.00 to the Provincial Govern-

ment, a total of \$100.00. Now, as I said at the beginning,

I did not bring out the figures. They could be higher,

they could be lower, and we leave it to the experts.

Yourselves and ourselves, to work it out. Assuming

the experts also take the figures, the program

would involve, increase in income tax to the extent of

\$100.00 a year for the average family of two children,

having an average income of \$5,000.00, and correspondingly

higher amounts for people in higher income brackets.

MR. BAKER. Now, you said that, we

have said that income tax is the main thing that is the

question.

...to the question.

MR. BAKER. Generally speaking,

yes.

...Thank you.

very much. Now, may I turn to another question.

page 4 of your statement, in paragraph (c) you have

recommended that the Federal Government should be authorized

by the Department of Health and Human Services, Provisional

and local levels, and in paragraph (d) of your dissenting

views, and on page 110 of the interim report of the

Advisory Planning Committee on National Care, you said,

it may appear: "I want to go to the point of opposing

any form of government organization," and I am just

quoting this paragraph in support of what you say in



1 paragraph (h), that you are in favour of administration
2 by the Departments of Health, rather than in favour of
3 setting up semi-autonomous Commissions, such as one
4 has been proposed for Saskatchewan. . . . Would you perhaps
5 elaborate for the benefit of the Commission, just
6 briefly, why you are opposed to the establishment of
7 a semi-autonomous Commission such as being proposed here
8 in Saskatchewan?

9 MR. SMISHEK: I gather, sir, that the
10 Members of the Commission have had copies of the Interim
11 Report, and have very likely read it. . . . I think that
12 we have, I have tried to explain the reasons in my
13 dissenting views, also in the appendix to our brief
14 we give our broad reasons for it. . . . We feel that it is
15 better to have a health program under sort of one
16 administration, rather than several administrations
17 which leads to fragmentation, and we feel that by and
18 large that there should be one administrative body
19 administering health services, because there is a need
20 for co-ordination of health services. . . . The more ad-
21 ministrative bodies one establishes, the more it tends
22 to fragmentation, and we do not subscribe to the
23 preposition that Commissions are immune from political
24 influence and political interference. . . . Our experience
25 is that, knowledge, that if there is ways, if one wants
26 to devise those Commissions to have political opinions,
27 that that is possible, and we feel that health services
28 would be better administered generally under one body.
29 We do have faith in governments, and in the general
30 administration of governments, even though we might



paragraph (a). That you are in favour of administration
by the Department of Health, rather than in favour of
setting up semi-autonomous Commission, such as one
has been proposed for Saskatchewan. Would you perhaps
elaborate for the benefit of the Commission, that
briefly, why you are opposed to the establishment of
a semi-autonomous Commission such as being proposed here
in Saskatchewan?

MR. MILLER: I gather, sir, that the
Members of the Commission have had copies of the Interim
Report, and were very likely told that I think that
we have, I have tried to explain the reasons in my
opening views, also in the appendix to our brief
we give our broad reasons for it. We feel that it is
better to have a single power under sort of one
administration, rather than several administrations
which leads to fragmentation, and we feel that by and
large that there should be one administrative body
administering health services, because there is a need
for co-ordination of health services. The more ad-
ministrative bodies and establishments, the more it tends
to fragmentation, and we do not subscribe to the
proposition that Commissions are immune from political
influence and political interference. Our experience
is that, knowledge, that if there is ways, if one wants
to devise those Commissions to have political opinions,
that that is possible, and we feel that health services
would be better administered generally under one body.
We do have faith in government, and in the general
administration of governments, even though we might



1 differ with them from time to time, and we do not
2 accept this preposition that somehow Commissions can-
3 not be interfered with, somehow Commissions can do,
4 you know, more effective jobs. Probably putting it
5 simply, we feel that because of the need for co-ordin-
6 ated programs, it is better to have one agency, and that
7 is why we have Departments of Health, and this should
8 be their responsibility.

9 COMMISSIONER FIRESTONE: Let us ex-
10 amine how your proposal would work? Let us say the
11 medical health plan were administered by the Department
12 of Public Health, would you presume that the Department
13 would pay for this program as it pays for all other
14 programs, from a vote which has been passed by your
15 Legislature, which has been turned over to the Department
16 to administer? Is this the way it would work?

17 MR. SMISHEK: That is right, similar
18 to that, the hospital services program is administered
19 by the Department of Health.

20 COMMISSIONER FIRESTONE: A vote would
21 be passed and certain funds made available to the
22 Department. Would these funds that have been enumerated
23 to us by the Government of Saskatchewan, the Minister of
24 Health, coming from the three sources you will recall, the
25 premium, the sales tax, the one and a half percent,
26 and then the income tax too, all made up to cover this
27 particular vote?

28 MR. SMISHEK: Should that be a special
29 fund?

30 COMMISSIONER FIRESTONE: Yes?



simply, we feel that because of the need for co-ordin-
ated programs, it is better to have one agency, and that
in any way we have commitment of Health, and this should
be better responsibility.

Let us ex-
amine how your program would work. Let us say the
medical health plan were administered by the Department
of Public Health, would you agree that the Department
would pay for the program as it pays for all other
programs. I am a vote which has been passed by your
legislature, and it has been turned over to the Department
to administer. I think the way it would work
is similar. There is right, similar
to that, the medical services program is administered
by the Department of Health.

A vote would
be passed and certain funds would be available to the

to us by the Government of Saskatchewan, the Minister of
Health, sending from the three bodies you will recall, the
program, and after that the one and a half percent,
and then the income tax cut, all made up to cover this

MR. SMITH: Should that be a special



1 MR. SMISHEK: In my own case, and in
2 the case of the Federation, we have been really not too
3 concerned that there should be sort of a special fund,
4 remembering at times that the fund might not be accurate
5 ---

6 COMMISSIONER FIRESTONE: Exactly sir.

7 MR. SMISHEK: And therefore general
8 revenues, you know, might be necessary. There are
9 those who advocate that there should be a separate fund.
10 I might say that we really have not got any firm opinions
11 on that. We have at this time, we haven't had any
12 one really demonstrate to us that there is advantages
13 in having a special fund set up, or that there are
14 disadvantages in not having one set up.

15 COMMISSIONER FIRESTONE: Would you not
16 feel that it might put the mind of the College of
17 Physicians, and the practising physicians, at rest
18 if they were sure that the money that is collected for
19 a medical care plan is used for medical care services,
20 rather than put in a general revenue fund, and you are
21 not sure the physicians get the money the Province of
22 Saskatchewan is collecting for that particular purpose.
23 Would you not feel it would be reassuring for them
24 to know that so much money is collected for this purpose,
25 and they are getting it? This would not be known if
26 this money went into general revenue and a vote
27 were made to that Department to administer as they saw
28 fit?

29 MR. SMISHEK: I cannot answer for them.
30 It might be more reassuring, I don't know.



MR. SMITH: In my own case, and in

the case of the N. A. we have been really not too
concerned that there should be sort of a special fund,
remembering as I think that the fund might not be available

MR. SMITH: And I suppose General

remember, very much, might be necessary. There are
those who are afraid that there should be a separate fund.
I might say that we have not yet any firm opinion
on that. We have at this time, we haven't had any
one really concerned as to that. It is advantageous
in having a special fund and we are not there are
advantages in not having one at all.

MR. SMITH: Would you not

that, that is what you are afraid of the College of
Physiology, and the faculty of physiology, at least
if they were sure that the money was collected for
a special fund, as they are for medical care services,
rather than put in a general revenue fund, and you are
not sure the possibility for the money the purpose of
Saskatchewan is collecting for that particular purpose.
Would you not feel it would be reasonable for them

to know that the money is collected for this purpose,
and they are getting it. This would not be known if
it was put into general revenue and a vote
were made to that Department to distribute as they saw

MR. SMITH: I cannot answer for them.

It might be more reasonable, I don't know.



1 COMMISSIONER FIRESTONE: Would you not
2 feel that the Federation would support any sort of
3 arrangement that would be not only satisfactory to those
4 receiving medical care services, but also to those
5 rendering medical care services?

6 MR. SMISHEK: Yes, I think we have in our
7 submission to the Thompson Committee said that the program
8 should be devised which is generally acceptable to both
9 those providing the service and those receiving it.

10 COMMISSIONER FIRESTONE: You realize the
11 College of Physicians has put a great deal of emphasis
12 on the necessity for fiscal autonomy. They want to be
13 sure whatever scheme is devised and they prefer a
14 voluntary scheme to a compulsory scheme; in fact, they
15 don't even like the word "scheme"; I should say "plan", or
16 "program"; but whatever is developed, they would like to
17 see it administered in such a way that the funds collected
18 to pay for medical services are used for that purpose.
19 If this is their desire, why could not the Saskatchewan
20 Federation of Labour support such an objective as long
21 as you achieve what you are after, which is comprehensive
22 universal coverage?

23 MR. SMISHEK: We will be willing to meet
24 with the College of Physicians and Surgeons to discuss
25 any principal points on which we could reach agreement,
26 if that was an important part of it.

27 COMMISSIONER FIRESTONE: From the way it
28 sounded it sounds important to be able to work out a
29 co-operative arrangement in which everyone can participate,
30 and I am reassured by those considering it that it was, sir.

arrangement that would be not only satisfactory to those
receiving medical care services, but also to those

MA. SWANSON: Yes, I think we have in our

emphasis to the Thompson Committee said that the program
should be devised which is generally acceptable to both
those providing the service and those receiving it.

COMMISSIONER FLINSTONE: You realize the

College of Physicians has put a great deal of emphasis

on the necessity for fiscal economy. They want to be

sure whatever scheme is devised -- and they prefer a

voluntary scheme to a compulsory scheme; in fact, they

don't even like the word "compulsory"; I would say "plan",

"program"; but whatever is developed, they would like to

see it administered in such a way that the funds collected

to pay for medical services are used for that purpose.

If this is their desire, why could not the Saskatchewan

Association of Labour support such an objective as long

as you believe what you are after, which is comprehensive

with the College of Physicians and Surgeons to discuss

any mutual points on which we could reach agreement,

if that was an important part of it.

COMMISSIONER FLINSTONE: From the way it

and I am reassured by those considering it that it was, sir.



1 May I now turn to page 9, paragraph g. :
2 you say under g: "What is perhaps the most important
3 objection to the private plans is that they are not
4 concerned with the quality of medical care." We have
5 been told by the College of Physicians that under a
6 public scheme such as is now being introduced in
7 Saskatchewan, the quality will suffer. You say the
8 opposite. Could you elaborate, please?

9 MR. SMISHEK: Well, I think that question
10 was asked previously. I think in the previous paragraph
11 we say that the private plans are at the present time
12 primarily concerned about diagnostic and curative services.
13 They do not concern themselves about research, either
14 medical or administrative research. While they might
15 concern themselves with medical rehabilitation, they
16 do not concern themselves with occupational rehabilitation.
17 Primarily they are insurance programs.

18 THE CHAIRMAN: Mr. Smishek, do you suggest
19 that the Act does any of those things -- concerns itself
20 with any of those things, as it was enacted by the
21 Legislature?

22 MR. SMISHEK: Well, we are certainly
23 hopeful ---

24 THE CHAIRMAN: Well, you are comparing
25 the present scheme with the present Act, are you not?

26 MR. SMISHEK: No, I am not comparing the
27 present Act ---

28 THE CHAIRMAN: If you are going to make
29 a comparison----?

30 MR. SMISHEK: I am not making any com-



1 You are under the "What is perhaps the most important
 2 objection to the private plan is that they are not
 3 concerned with the quality of medical care." We have
 4 been told by the College of Physicians that under a
 5 public scheme such as is now being introduced in
 6 Scandinavia, the quality will suffer. You say the
 7

8 was asked previously. I think in the previous paragraph
 9 we say that the quality is not at the present time
 10 primarily concerned about diagnostic and curative services.
 11 They do not concern themselves about research, either
 12 medical or biological. No research. Well, they might
 13 concern themselves with medical research, but they
 14 do not concern themselves with biological rehabilitation
 15 primarily they are interested in

16 THE CHAIRMAN: Mr. Chairman, do you suggest
 17 that one can come out of those things -- concerns itself
 18 with any of those things, as it was covered by the
 19 legislation?

20 MR. SMITH: Well, we are certainly

21 THE CHAIRMAN: Well, you are comparing
 22 the present scheme with the present Act, are you not?

23 MR. SMITH: No, I am not comparing the

24 MR. SMITH: I am not making any com-



1 parison with the present Act. I am trying to answer the
2 question posed.

3 THE CHAIRMAN: You are saying the private
4 schemes are limited to the furnishing of physicians'
5 services, and by virtue of that are inferior to the
6 provincial scheme?

7 MR. SMISHEK: We have also said we are
8 not completely satisfied ----

9 THE CHAIRMAN: But do you recognize or
10 do you not that the present Act goes no further in that
11 coverage than the private schemes?

12 MR. SMISHEK: Well, we will differ, but
13 the Legislation does provide for broader coverage than
14 the voluntary schemes.

15 THE CHAIRMAN: But is there any provision
16 for research, for instance?

17 MR. SMISHEK: I think this is something
18 the Commission has power to consider.

19 THE CHAIRMAN: You mean be able to
20 divert part of the money it collected for doctors'
21 services into research?

22 MR. SMISHEK: Not necessarily, but they
23 certainly have --- from this, that the tax structure --
24 what is proposed is not only the fund that might be
25 made available. Certainly, it seems there is nothing
26 to prevent the Commission from going to the Government
27 and asking for money to be allocated or additional funds
28 be allocated for research.

29 THE CHAIRMAN: You mean additional
30 taxation?



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THE CHAIRMAN: Now do you recognize as
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to prevent the Commission from going to the government

and asking for money to be allocated or additional funds

be allocated for research.

THE CHAIRMAN: You mean additional



1 MR. SMISHEK: That is right.

2 THE CHAIRMAN: That is right, I suppose.

3 COMMISSIONER FIRESTONE: Well now, sir,
4 if we understand the physicians correctly, they say that
5 under the present arrangements they are giving the people
6 of Saskatchewan the best quality of medical care service
7 they know. They also feel that under the public
8 scheme which would involve controls, which would take
9 away the incentives they have now, that the quality of
10 the service which they provide might be gone. I am
11 not referring now to the sort of things you included
12 in your answer, that there be additional services rendered.
13 They are talking of the quality of the medical care
14 services which are provided now as compared with the
15 quality of the same services provided under the public
16 scheme and under public control. They say that quality
17 will decline, and this is not in the interests of the
18 people of Saskatchewan. What are your views on this
19 point?

20 MR. SMISHEK: We don't know why quality
21 should decline under a public program as compared to a
22 voluntary program. We think basically the opposite,
23 and certainly there are public programs in effect in
24 other countries and there is no proof that quality had
25 declined. In fact, there is an abundance of material
26 written that quality had improved.

27 THE CHAIRMAN: As you said at the be-
28 ginning, it depends on whose book you read.

29 MR. SMISHEK: That is right.

30 COMMISSIONER FIRESTONE: To come back to



MR. SMITH: That is right.

THE CHAIRMAN: That is right, I suppose.

if we understand the physicians correctly, they say that under the present arrangements they are giving the people of Saskatchewan the best quality of medical care service they know. They also feel that under the public scheme which would involve controls, which would take away the incentives they have now, that the quality of the service which they provide might be gone. I am not referring now to the sort of things you included

in your answer, that there be additional services rendered. They are talking of the quality of the medical care services which are provided now as compared with the quality of the same services, would under the public scheme and under public control. They say that quality will decline, and that is not to the interests of the people of Saskatchewan. What are your views on this point?

MR. SMITH: We do know why quality should decline under a public program as compared to a voluntary program. We think basically the opposite, and certainly there are public programs in effect in other countries and there is no doubt that quality has declined. In fact, there is an abundance of material

THE CHAIRMAN: As you said at the beginning, it depends on whose book you read.

MR. SMITH: That is right.

COMMISSIONER FINESTONE: To come back to



1 the situation in Saskatchewan, and don't let us read
2 books, but let us look at the actual situation as you
3 find it and the actual situation as it may develop under
4 the scheme as proposed. In examining what proposals
5 you may put forward to the Saskatchewan Government ---
6 and I am now referring to the Advisory Planning Committee
7 on Medical Care --- did the question of quality of
8 medical care service come up, and did you have an
9 opportunity of looking into this claim of the medical
10 profession that this quality would suffer, and, if so,
11 with what evidence did you come up either in support
12 of that claim or to contradict it? We would like to
13 know the answer. We have been told this in a number
14 of provinces, we have gone to and, as Commissioners,
15 we would like to know is it or is it not, as far as the
16 Canadian situation is concerned, and you people in
17 Saskatchewan are ahead of the parade and perhaps you
18 know the answers.

19 MR. SMISHEK: Well, sir, I don't think
20 I should be placed in a position of trying to answer for
21 the Thompson Committee. I think this is the type of
22 question that probably may be best directed to the
23 Thompson Committee, and the Committee as a whole may
24 consider and give you a reply. I am not here as a
25 member of the Thompson Committee appearing before you.
26 I am here as the Executive-Secretary of the Saskatchewan
27 Federation of Labour.

28 COMMISSIONER FIRESTONE: This is a very
29 fair answer. I am, therefore, addressing the question
30 to you as a representative of the Saskatchewan Federation



the situation in Saskatchewan, and don't let us read
books, but let us look at the actual situation as you
find it and the actual situation as it may develop under
the present government.
You may put forward to the Saskatchewan Government --
and I am now referring to the Advisory Planning Committee
on Medical Care -- and the question of quality of
medical care service comes up, and did you have an
opportunity of looking into this side of the medical
situation?
With what evidence did you come up either in support
of that side or the other side? We would like to
know the answer. As we have seen this in a number
of provinces, we have gone to and as Commissioners,
we would like to know as far as it goes, as far as the
situation in Saskatchewan is concerned, and you people in
Saskatchewan are ahead of the game and perhaps you
know the answer.
MR. SMITH: Well, sir, I don't think
I should be placed in a position of trying to answer the
the question Committee. I think this is the type of
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I am here as the Executive Secretary of the Saskatchewan
Federation of Labour.
COMMISSIONER: This is a very
this answer. I am, therefore, addressing the question
to you as a representative of the Saskatchewan Federation



1 of Labour: have you in your efforts and in your in-
2 cidental participation in the Thompson Committee come
3 across any evidence which would support your claim that
4 the quality of medical care will not suffer under a
5 public scheme?

6 MR. SMISHEK: Well, I am so far not
7 convinced that it will suffer. I am of the opinion
8 that over a period of time the quality of care will be
9 enhanced to the public.

10 COMMISSIONER FIRESTONE: Therefore, you
11 are not taking seriously the warnings of the medical
12 profession, who should know because, after all, they are
13 providing that service, and, after all, if the people
14 who provide the service don't know what will happen to
15 the service, who should know?

16 MR. SMISHEK: Fear of the unknown might
17 be at times quite dangerous.

18 COMMISSIONER FIRESTONE: In other words,
19 you are not taking the warning of the medical profession
20 as a serious threat to reducing the quality of services
21 in the Province of Saskatchewan?

22 MR. SMISHEK: The answer is "No."

23 COMMISSIONER FIRESTONE: I have one last
24 question, and I am referring to paragraph 42 on page
25 15 of your submission: You speak there of over-all
26 resource planning in connection with the searching out
27 and determining of medical health personnel in numbers,
28 quality, training et cetera. If I understand the
29 spirit and the general conclusions of your brief correctly,
30 you are in favour of over-all planning in the health field?



of Labour, have you in your efforts and in your in-
cidental participation in the Thompson Committee come
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the quality of medical care will not suffer under a
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you are not taking the warnings of the medical profession
as a serious matter to reducing the quality of services
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MR. SMILSHAK: The answer is "No."

COMMISSIONER FIRSTONE: I have one last
question, and I am referring to paragraph 42 on page
12 of your submission. You speak there of over-all
resource planning in connection with the searching out
and determining of medical health personnel in numbers,
quality, training of careers. If I understand the
spirit and the general conclusions of your brief correctly,
you are in favour of over-all planning in the health field?



1 MR. SMISHEK: That is right.

2 COMMISSIONER FIRESTONE: Could you suggest
3 to the Commissioners how this over-all planning could
4 be achieved?

5 MR. SMISHEK: Well, this is certainly not
6 a simple question to answer.

7 COMMISSIONER FIRESTONE: May I be of
8 help to you---

9 MR. SMISHEK: I think it will require
10 the cooperation of Departments of Health throughout
11 Canada; it will require the cooperation of the professions;
12 it will also require the cooperation of the people in the
13 education field. It will require a good deal of
14 research and study in achieving that kind of national
15 planning and making decisions which look to be in the
16 best interest of the people. Now, certainly it may be
17 that errors will be made, but through errors we would
18 learn.

19 COMMISSIONER FIRESTONE: Mr. Smishek,
20 you are quite right in saying it is a very difficult
21 question, and we are turning to you as a man who has
22 studied this problem very carefully. You have expressed
23 very independent and intelligent views on the subject.
24 Some people will agree and some will not. I was
25 wondering whether you and your associates in the
26 Federation could give some thought to specific proposals
27 as to how this over-all planning in the field of health
28 services could be carried on at the national level, at
29 the provincial level and at the local level, and what
30 kind of cooperation could be worked out between the three



Could you suggest

to the Committee now how this over-all planning could

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as to how this over-all planning in the field of health

services could be carried on at the national level, at

the provincial level and at the local level, and what

kind of cooperation could be worked out between the three



1 different levels of government involved in the field of
2 providing and improving health services for Canada.
3 Could some thought be given to this and could your
4 Association at a later date make available to the
5 Commission your views in writing so that we have the
6 benefit of your views, and I am referring to specific
7 things rather than to broad generalities, because the
8 Commissioners are in a difficult position when they make
9 the recommendation that they have to be specific,
10 and we like to be as specific as we can be in the light
11 of advice we can get from people who are experts in the
12 field.

13 MR. SMISHEK: We might try to attempt
14 this. It is, as you appreciate, a very difficult kind
15 of project. In addition to that, our Federation is
16 limited in its facilities, but we will try to attempt
17 to do that, sir.

18 COMMISSIONER FIRESTONE: I would be
19 prepared to offer you an alternative if that is preferable
20 to you: if you found your resources are limited, and
21 you can persuade your parent body to make such a sub-
22 mission to us we would welcome this just as much as
23 we would welcome any views your Association would submit
24 to us.

25 MR. SMISHEK: We would pose this also
26 to the Canadian Labour Congress and they might be able
27 to come up with some more detailed conclusions for you.

28 COMMISSIONER FIRESTONE: As long as we
29 get it from somebody within the time of the existence
30 of the Commission. May I end up by saying to you, Mr.



different levels of government involved in the field of
providing and improving health services for Canada.
Could some thought be given to this and could your
Association at a later date make available to the
Commission your views in writing so that we have the
benefit of your views, and I am referring to specific
things rather than to broad generalities, because the
Commissioners are in a difficult position when they take
the recommendation that they have to be specific,
and we have to be as specific as we can be in the light
of advice we can get from people who are experts in the
field.
We might try to attempt
this. It is, as you indicated, a very difficult kind
of project. In addition to that, our Federation is
limited in its ability, but we will try to attempt
to do this.
I would be
prepared to offer you an alternative if that is preferable
to me. At the same time, your resources are limited, and
you can purchase your paper only to make such a sub-
mission as you would want to make just as much as
we would welcome any other Association would submit.
We would have this also
to the Canadian Labour Congress and they might be able
to come up with some more detailed conclusions for you.
Commissioners' Response: As long as we
get it from somebody within the time of the existence



1 Smishek, thank you very much for your constructive replies;
2 you have been very helpful to us.

3 COMMISSIONER STRACHAN: Mr. Smishek,
4 it has been stressed to this Commission that there is
5 a definite shortage of health personnel. Are you
6 satisfied that following your suggested program that
7 more of the youth of this country will enter the health
8 professions, admitted that at the present time we have
9 a captive group in the health professions but they will
10 soon pass to the beyond. Are you quite sure and
11 satisfied that your program will encourage the youth of
12 Canada to enter the health professions in the future?

13 MR. SMISHEK: Yes, we are, sir, and I
14 think there is some evidence in some areas that where
15 public programs have existed, with more finances being
16 provided, with better organization, that more people
17 have entered the professions. To think of one country
18 at the moment, Norway, which country is training, it
19 seems to me, a much larger number of people in the health
20 field proportionately than any countries we have seen
21 so far --- probably because of their method of organization
22 because of the willingness to provide the funds.

23 COMMISSIONER STRACHAN: Would you care
24 to think of England at the moment, then?

25 MR. SMISHEK: Well, in England there are
26 still shortages, and this is admitted remembering that
27 their program is still comparatively a new program.
28 It has only had a 12 or 13 year duration.

29 COMMISSIONER STRACHAN: But the youth
30 is getting into age and they don't appear to be entering



Mr. STRAHMAN:

it has been stressed to this Commission that there is a definite shortage of health personnel. Are you satisfied that following your suggested program that more of the youth of this country will enter the health professions, admitted that at the present time we have a captive group in the health professions but they will soon pass to the general. Are you quite sure and satisfied that your program will encourage the youth of Canada to enter the health professions in the future?

Mr. STRAHMAN: Yes we are, sir, and I

think there is some evidence in some areas that where

provided, with better organization, that more people have entered the professions. To think of one country at the moment, Norway, which country is training, it seems to me, a much larger number of people in the health field proportionately than any countries we have seen

at the moment, because of the willingness to provide the funds.

Would the STRAHMAN: Would you care

to think of Norway at the moment, they

Mr. STRAHMAN: Well, in England there are still shortages, and this is admitted remembering that their program is still comparatively a new program. It has only had a 10 or 15 year operation.

COMMISSIONER STRAHMAN: But the youth

is getting into age and they don't appear to be entering



1 the health professions as they did in the past.

2 MR. SMISHEK: I don't think this is
3 because of the health service. There is evidence to
4 the contrary in other countries.

5 THE CHAIRMAN: Mr. Smishek, just one
6 item I would like your view on --- the view of the
7 Saskatchewan Federation of Labour: The Thompson
8 Committee report limited itself to a recommendation on
9 physicians' services. I understand that was not a
10 decision of the Committee, but at the request of the
11 Government--- that the Interim Report dealt only with
12 specific recommendations for the physicians' service
13 program; that is right, isn't it?

14 MR. SMISHEK: That is right --- well,
15 again, if the details of what happened are of significance

16 ----
17 THE CHAIRMAN: I don't want the details.

18 MR. SMISHEK: The answer is that the
19 Government did request, and the Committee did agree to
20 provide an Interim Report, and under the terms of reference
21 of the Committee --- and it seems to me you are in the
22 same position, that the Government may request reports
23 from time to time --- this is right in the terms of
24 reference of the Thompson Committee, as you are probably
25 aware.

26 THE CHAIRMAN: Our terms of reference
27 are a matter of public knowledge, but that is not what
28 I am concerned with. What I am concerned with is
29 the question of priorities: in setting up the program
30 for physicians' services involving the provincial ex-



the health professions as they did in the past.

MR. SMITH: I don't think this is

because of the health service. There is evidence to

from I would like your view on -- the view of the

Association of Physicians of Japan; The Japanese

Committee report itself to a recommendation on

physician services. I understand that was not a

decision of the committee, but at the request of the

Government -- that the interim report dealt only with

general recommendations for the physician's service

program; that is right, isn't it?

MR. SMITH: That is right -- well

again, if the details of what happened are of significance

MR. SMITH: I don't want the details.

MR. SMITH: The answer is that the

Government did request, and the committee did agree to

provide an interim report, and under the terms of reference

of the Committee -- and it seems to me you are in the

same position, that the Government may request reports

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I am concerned with -- What I am concerned with is

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for physician services involving the physician ex-



1 penditure in the area of \$20,000,000.00, that is an
2 acceptance of using the tax resources of the Province
3 for the one service. Now, we have heard from re-
4 sponsible organizations like the Mental Health Association,
5 or the Retarded Children's Association, and others ---
6 particularly the Mental Health Association that the
7 condition of the services for mentally ill people in
8 Saskatchewan are really of a low order.

1 9 Now, does the Saskatchewan Federation of
10 Labour regard the providing of physicians' services
11 as being more important than the needs of the mentally
12 ill, the aged, the retarded and those other categories?

13 MR. SMISHEK: The answer to that is,
14 we think that all areas are important.

15 THE CHAIRMAN: I know you say you
16 support this physicians' plan and the government says that
17 this all the money they can now get for the improvement
18 of health services in Saskatchewan. Do you approve of
19 using all the revenue available on this one facet of
20 physicians' services leaving the condition of the
21 mentally ill, the aged, the retarded and so forth as
22 they are now for the future to take care of them.

23 MR. SMISHEK: Well, sir, we do agree
24 with the Act that has been passed, the Saskatchewan
25 Medical Insurance Act.

26 THE CHAIRMAN: Does that mean that is
27 your number one priority?

28 MR. SMISHEK: We also agree --

29 THE CHAIRMAN: Does that mean that is
30 your number one priority? You can answer that yes or



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condition of the services for mentally ill people is

unacceptable and really of a low order.

Now, does the Saskatchewan Federation of

labor regard the providing of psychiatric services

as being more important than the needs of the mentally

ill, the aged, the retarded and those other categories?

MR. SMITH: The answer to that is,

no, I think that all sides are important.

THE CHAIRMAN: I know you say, on

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is all the money they can get for the improvement

of health services in Saskatchewan. Do you approve of

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with the fact that has been passed, the Saskatchewan

THE CHAIRMAN: Does that mean that is

your number one priority?

MR. SMITH: We also agree --

THE CHAIRMAN: Does that mean that is

your number one priority? You can answer that yes or



1 no or if you prefer not to answer it

2 MR. SMISHEK: It is a difficult question
3 to answer by yes or no; we do not think that it can be
4 answered that simply.

5 THE CHAIRMAN: Surely somebody made a
6 decision to either proceed with physicians' services
7 or proceed with services to some other needed area.

8 MR. SMISHEK: In the over-all health
9 field there is a tremendous need.

10 THE CHAIRMAN: But with need in several
11 areas you have chosen one and is that because you regard
12 it as the one deserving of the priority?

13 MR. SMISHEK: We think that by providing
14 the program it will help in the other areas.

15 THE CHAIRMAN: In the meanwhile, the
16 others can wait their turn?

17 MR. SMISHEK: In the meanwhile we would
18 also hope that probably in the mental health field that
19 the time is not far distant when the Federal Government
20 will be able to provide some additional money.

21 THE CHAIRMAN: This was a provincial
22 committee, it is Provincial Legislation and the care
23 of the mentally ill is a provincial responsibility.
24 In that context do you regard the providing of physicians'
25 services as being entitled in priority of time over
26 the needs of the mentally ill?

27 MR. SMISHEK: Well, the very fact ,
28 probably it could be interpreted the very fact we do
29 support the introduction of Medical Insurance Act
30 possibly could be interpreted that that is the priority



no or if you prefer not to answer it

MR. SWANSON: It is a difficult question

to answer by yes or no; we do not think that it can be

MR. SWANSON: I think somebody made a

decision to either proceed with physical services

or proceed with services to some other health area.

MR. SWANSON: In the over all health

field there is a tremendous need.

Now you have shown one of the areas you regard

it as the one deserving of the priority.

MR. SWANSON: I think that by providing

the program it will help in the other areas.

Others can well believe that.

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possibly could be interpreted that that is the priority



1 we support.

2 THE CHAIRMAN: Thank you very much.
3 You have been very helpful to us. I am sorry there
4 has been a delay in hearing your submission which has
5 resulted in some of your members not being here, but
6 these things do happen.

7 MR. SMISHEK: I appreciate that.

8 THE CHAIRMAN: The brief that you have
9 submitted gives every indication of careful consideration
10 and study and manifest interest which we appreciate.

11 MR. SMISHEK: Thank you very much.

12 THE CHAIRMAN: We will take a short
13 recess and then hear Dr. Hoffer's brief.

14
15 -----SHORT RECESS

16
17 THE CHAIRMAN: We will now receive
18 Dr. Hoffer's brief.

19 THE SECRETARY: This will be Exhibit
20 87.

21
22 -----EXHIBIT No. 87: Submission of Dr. A. Hoffer
23
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THE CHAIRMAN: Thank you very much.

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MR. SWANBERG: I appreciate that.

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---EXHIBIT No. 87: Submission of Dr. A. Hoffer



SUBMISSION OF DR. A. HOFFER, B.S.A., M.S., Ph.D., M.D.

THE CHAIRMAN: Dr. Hoffer, if you will tell the Commission not only who you are but your present position and your background in the light of this very scholarly brief.

DR. HOFFER: Thank you. Before I start I would like to thank you and the Commission for giving me this opportunity to appear before you. I would like to tell you in a very few moments why I am here, what I have tried to do in the brief and a very brief review of the three aspects of the research process but not of the content and finally my prescription for meeting such psychiatric research in Canada. As a physician I feel quite safe in giving prescriptions. Now, I would like to complete my remarks with this prescription.

I am here today basically because of my great interest in the field of psychiatric research in Canada. At the moment I am Director of Psychiatric Research for the Department of Public Health in the psychiatric service branch of this Government and I have had this position for the past ten years. I have had approximately two decades of research experience spread out in the field of plant pathology, working onto the field of baking and ending up in the field of psychiatric research. I have, therefore, seen how the research programs have developed in this country.



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spread out in the field of plant pathology, working

into the field of baking and ending up in the field of

psychiatric research. I have, therefore, seen how

the research programs have developed in this country.



1 What I have tried to do in my written
2 submission is to outline to you as accurately as I can
3 the research situation in Canada and how it developed
4 because I thought it would help you in your deliberations
5 if you could see some historical development. Then,
6 I tried to develop the research program in Saskatchewan
7 because I think when we see something grow it is easier
8 to see what the problems are. I should state right
9 off that I am not complaining or criticising anyone,
10 I think we have a very fine research program in this
11 Province and my own personal bias appears here but I
12 would like to see a great improvement in this help.

13 Going to the problem of research itself,
14 there are three aspects; the research personnel, the
15 scientists. Of course, there must be some money, the
16 scientists must eat. Finally, there must be a place in
17 which to work. There must be a balanced program be-
18 tween all these three aspects.

19 For this introduction I will merely list
20 my prescription for improving the roll of psychiatric
21 research.

22 1. More money and it is my recommendation
23 that we should devote 5% of the total estimated cost
24 of psychiatric care in Canada. This would come to
25 about \$18,000,000.00 for the whole of Canada. I am
26 not suggesting this should be made available tomorrow
27 but there should be a program with this aim in mind so
28 eventually in a balanced program this would be the over-
29 all objective and this would bring us into line with the
30 experience in the United States.



What I have tried to do in my written submission is to outline to you as accurately as I can the research situation in Canada and how it developed because I thought it would help you in your deliberations if you could see some historical development. Then, I tried to develop the research program in Saskatchewan because I think when we see something grow it is easier to see what the problems are. I should state right off that I am not complaining or criticizing anyone, I think we have a very fine research program in this Province and my own personal bias appears here but I would like to see a great improvement in this help.

Going to the problem of research itself, there are three aspects; the research personnel, the scientist. Of course, there must be some money, the administrative cost. Finally, there must be a place in which to work. There must be a balanced program between all these aspects.

For this introduction I will merely list my suggestions for improving the role of psychiatric hospitals and it is my recommendation that we should devote 5% of the total estimated cost of psychiatric care to research. This would come to about \$18,000,000 for the whole of Canada. I am not suggesting this should be made available tomorrow but there should be a program with this aim in mind so eventually in a balanced program this would be the over-all objective and this would bring us into line with the experience in the United States.



1 THE CHAIRMAN: That is for the whole of
2 Canada?

3 DR. HOFFER: Yes sir, over the whole of
4 Canada.

5 2. Improvements in the method of dis-
6 tribution of grants. I am recommending here enough
7 budgets for well established research programs in the
8 same way we have in the budgets in this Province for
9 our research program. I am also suggesting initial
10 grants to help people get started before we are quite
11 sure whether these scientists will be able to do a good
12 job. With these two types of grants I think there
13 should be a great improvement.

14 3. I am suggesting that we have
15 research salaries. Most of the research people in
16 Canada today are on salaries and there is an in-
17 equality of payment with reference to professional groups
18 of research physicians. These people ought to be paid
19 commensurate with their responsibility and comparable
20 to the payment of other physicians in the services. I
21 am also suggesting that there ought to be an equality
22 between the scientists. There is today in Canada some
23 discrepancy of payment received by social scientists
24 and physical scientists. In our Province bio-
25 chemists are entitled to more pay than our psychologists
26 even though they do work of no responsibility. I think
27 this should be questioned.

28 4. I am suggesting additional rewards for
29 research people in the form of sabbatical years, in the
30 supplying of funds to travel to research meetings and



THE CHAIRMAN: That is for the whole of

MR. HOBBS: Yes sir, over the whole of

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I am suggesting additional rewards for

research people in the form of additional years, in the

supplying of funds to travel to research meetings and



1 some kind of public recognition. Here I would like to
2 quote Dr. Spinks who recently proposed that research
3 scientists should have some recognition. He was quite
4 upset because you will recall he said that a famous
5 athlete in Canada received much more recognition than
6 research scientists.

7 5. I suggest there ought to be three
8 psychiatric research centres in Canada and I would
9 prefer that one of them be in Saskatoon.

10 6. That there ought to be in Canada
11 a central research library which would assist the out-
12 lying areas in obtaining information that they need.
13 This would provide translation services, abstract services,
14 lending material and even a place where scientists could
15 go to the library to spend two or three months to become
16 up to date with their material.

17 These are my recommendations and I think
18 if these were carried out to some degree I would expect
19 to see a great improvement in the health of psychiatric
20 research in Canada.

21 THE CHAIRMAN: Thank you very much.
22 Now, as you will appreciate, there are some members of
23 the Commission who may not wish to enter into any detailed
24 discussion on many aspects of your very scholarly
25 submission which is almost a volume in itself and must
26 represent on your part a tremendous amount of work.
27 This is a contribution that this Commission is going
28 to appreciate and does appreciate very highly. Necessarily
29 much of what you cover here is technical in its
30 aspects and will go to our research director and staff



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2 quote Dr. Spinks who recently proposed that research
3 scientists should have some recognition. He was quite
4 upset because you will recall he said that a famous
5 athlete in Canada received more recognition than
6 research scientists.
7 I suggest there ought to be first
8 psychiatric research centres in Canada and I would
9 prefer that one of them be in the Kitchener
10 area. There were ought to be in Canada
11 a general research library which would assist the out-
12 lying areas in obtaining information and they need
13 this would provide information services, abstract services,
14 leading material and even a place where scientists could
15 go to the library to spend part of their money to become
16 up to date with their material.
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18 if these were carried out to some degree I would expect
19 to see a great improvement in the health of psychiatric
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28 to appreciate and does appreciate very highly. Necessary
29 much of what you cover needs to be followed in its
30 aspects and will go to our research director and staff



1 and will be extremely valuable to the scholars who
2 are undertaking studies in the field of mental health
3 in this Commission., Dr. Richmond and Dr. McKerracher.
4 I am satisfied that it will save them both hours and
5 days of work and research with the ready references
6 and footnotes that you have made available to them
7 in this submission. Dr. Baltzan?

8 COMMISSIONER BALTZAN: I just want to
9 add my thanks to Dr. Hoffer for supplying us with this
10 valuable information.

11 COMMISSIONER VAN WART: Just one or
12 two questions. You state a central research library;
13 Do you visualize that, for instance, in Ottawa or do
14 you mean that on a provincial basis?

15 DR. HOFFER: I would envisage that
16 in Ottawa, one central, main library for Canada which
17 might be similar to the Army library in Washington.
18 I do not think the provinces can really afford to set
19 up a large enough library to provide their own needs.
20 It may only mean a very large expansion of the National
21 Research Council library which they now have. However,
22 more important than the library would be the right of
23 research people in the Province to draw upon the
24 resources of this library.

25 COMMISSIONER VAN WART: At the present
26 time can you receive extracts or volumes on loan
27 from the research library.

28 DR. HOFFER: Yes sir, but we do not have
29 first priority. For instance, there was a meeting
30 held in Moscow and there are ten volumes that have come



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 up a large enough library to provide their own needs.
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 time can you receive extracts or volumes on loan
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Dr. Hoffer: Yes sir, but we do not have
 first priority. For instance, there was a meeting
 held in Moscow and there are ten volumes that have come



1 out. This is a very expensive proposition and the
2 National Research Council have a volume but their own
3 scientists have priority. I have been advised it may
4 be 9 months before I can expect to see it.

5 THE CHAIRMAN: You were talking about
6 the matter of grants, perhaps in reference to them being
7 on a budget basis so that there will be some certainty
8 of continuity. Can you suggest any instances where
9 there has been some breakdown because of a grant, a
10 specific grant coming to an end before the project was
11 finished or something like that?

12 DR. HOFFER: I do not have any specific
13 instances because in this Province we have not had to
14 face this problem. I do know one of the provinces
15 has refused to accept a great deal of grant money
16 for research for this particular reason. I cannot give
17 you any specific instances. In talking to the scientists
18 who worked with me I do know that they will not stay
19 unless there is some guarantee of security of tenure.
20 We now have a senior scientist with us, a senior bio-
21 chemist who was brought out on a scholarship basis
22 and we are at the moment transferring him from a
23 scholarship basis to a permanent basis.

24 THE CHAIRMAN: Now, the initial grants
25 would they be initiated, as I understand it, to sort
26 of prove the value of some project?

27 DR. HOFFER: That is right.

28 THE CHAIRMAN: Before it would go on
29 to becoming more or less of a permanent program until
30 a solution is reached?



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scientists have priority. I have been advised it may
be 9 months before I can expect to see it.
THE CHAIRMAN: You are talking about
the matter of finance. I think it is reasonable to them being
on a budget basis so that there will be some certainty
of financing. I am not suggesting any insurance where
there has been some withdrawal because of a grant. A
scientific grant coming in to help before the project was
initiated or something like that.
MR. HARRIS: I do not have any specific
information on this. Perhaps we have not had to
take this problem. I do know one of the problems
is related to securing a grant and it takes money
for research for this particular reason. I cannot give
you any specific instances. In talking to the scientists
who worked with me I do know that they will not stay
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We now have a senior scientist with us, a senior dis-
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would they be initiated, as I understand it, at sort
of prove the value of some project.
MR. HARRIS: That is right.
THE CHAIRMAN: Before it would go on
to financing more or less of a permanent program until
a contract is reached?



1 DR. HOFFER: I would think this would
2 be integrated with the research programs that are
3 being carried on. For instance, a young doctor
4 if he is finished his post-graduate training and
5 research training may wish to come in and work on a
6 certain idea. It may be after three or four years
7 that he finds himself not fit to do this particular
8 kind of research. The research personality has
9 certain idiosyncrasies. Also the people working
10 with him may find he is not capable of doing a good
11 job. I think in this case it would be dangerous
12 to research to put him on a permanent basis because
13 you would be saddled with a person less efficient than
14 what you could use. This would be a way of trying
15 out research people to see if they could do a job.

16 THE CHAIRMAN: In the matter of the
17 psychiatric centres, you spoke of the three,
18 would you envisage for the time being, for the
19 immediate future, that three in Canada would be
20 sufficient, would do a reasonable job?

21 DR. HOFFER: Yes, I would think so.

22 THE CHAIRMAN: What would the setting
23 up of such a psychiatric centre involve?

24 DR. HOFFER: It would include, first of
25 all, space for the creation of research institutes.
26 It would involve, secondly, providing an annual budget
27 to these centres so they could be secure in their
28 work. It would involve, finally, having a group of
29 scientists who are prepared to do the research.
30 I think it would be foolish to go to a province where



1 they have no research program and to tell them you
2 want to start a research institute. I think it is
3 much more sound if the Province come and say they
4 have a group of people and want a research institute. It
5 is more important to emphasize the scientist than it is
6 building.

7 THE CHAIRMAN: Do you contemplate these
8 institutions as being independent organizations or under
9 the aegis of a provincial university or something like
10 that?

11 DR. HOFFER: I think this would depend
12 on the particular location. I can visualize some
13 institutes would be under the control of the university.
14 I think, for instance, the new Research Institute at
15 Montreal will be controlled by McGill University. On
16 the other hand, in Saskatchewan I would prefer to see
17 a research institute under the control of the Department
18 of Public Health. The reason for that is that the
19 Department of Public Health of the Province created the
20 research and are now operating it. In contrast, at
21 McGill this was more of a university program than a
22 provincial program.

23 THE CHAIRMAN: So it is a matter of
24 picking up from where we are now, not jettisoning good
25 that has been done up to date.

26 DR. HOFFER: That is right, Mr.
27 Chairman.

28 COMMISSIONER VAN WART: In your
29 recommendation number 1 you say that much more money be
30 made available for psychiatric research and the ideal would



they have no research program and so tell them you want to start a research institute. I think it is

much more sound if the province come and say they

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that has been done up to date.

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Chair

COMMISSIONER VAN WAT: In your

view

made



1 be 5% of the cost of any problem. Do you mean 5%
2 of the money spent on psychiatric programs, 5% of it
3 for research?

4 DR. HOFFER: That is my recommendation.

5 COMMISSIONER VAN WART: Is that the
6 usual percent in research of monies available for
7 other projects besides psychiatry?

8 DR. HOFFER: It is very difficult to
9 compare. It depends on the kind of institution.
10 For instance, the major pharmaceutical industries
11 spend much more than that when their base line is
12 out. They have a sales volume base line they can
13 use and they will spend between 5% and 15% and perhaps
14 more. However, in the field of medical research
15 it is very difficult to know what is the optimum.
16 I am here using a figure which I think is ideal and
17 it also conforms with the American Association; they
18 come up with a figure of between 2% and 5% and I think
19 some of the wealthier States are approaching that
20 figure.

1 21 COMMISSIONER FIRESTONE: Dr. Hoffer,
22 this is a very thoughtful brief, and we are very grateful
23 to you for coming forward with specific suggestions for
24 a comprehensive research program. Sir, you have
25 suggested that such a research program may involve some-
26 thing like \$18,000,000.00 as a desirable target. Have
27 you any knowledge as to how much we are spending now on
28 psychiatric research?

29 DR. HOFFER: Yes, Dr. Firestone, I think
30 the best estimate would be somewhere between 800 and 900,000.

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of the money spent on psychiatric programs, 5% of it

for research?

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23 to you for coming forward with specific suggestions for

24 a comprehensive research program. Sir, you have

25 suggested that such a research program may involve some

26 thing like \$2,000,000.00 as a desirable target. Have

27 you any knowledge as to how much we are spending now on

28 psychiatric research?

DR. HOFFER: Yes, Dr. Frenstone, I think



1 It might even be a million dollars taking into account
2 the grants which have come up from South of the Border,
3 but I would think a million dollars would be reasonably
4 close.

5 COMMISSIONER FIRESTONE: I notice the
6 figure, I wanted it just as a basis for assessing
7 your recommendation. You are recommending roughly a
8 twenty-fold increase of what we are actually spending
9 at the moment. Dr. Hoffer, do we have enough research
10 scientists in this field to use the eighteen million
11 dollars constructively, serving the purposes that you
12 have in mind?

13 DR. HOFFER: We don't have them today,
14 but I was thinking of a program that might be aiming
15 toward a ten or twenty year target, and provided the
16 money were made available, I think we would have them
17 available then, but we do not have them today.

18 COMMISSIONER FIRESTONE: In other words,
19 if after this Commission of ours were to recommend
20 to the Canadian Government to participate with other
21 Governments in the development of such a program, which
22 twenty years from now would involve expenditures of
23 eighteen million dollars, this would be in line with
24 your recommendation. Now, Dr. Hoffer, twenty years
25 ahead is a wonderful target, but can we think of the
26 near term. What would you consider a more realistic
27 budget say for the next five years, per annum?

28 DR. HOFFER: Yes, I would guess here
29 that I would like to see it tripled in the next five
30 years.



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 2 the grants which have come up from South of the Border,
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 24 the program that you are talking about, but can we think of the
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 26 budget say for the next five years, per annum?

27 MR. HOFFER: Yes, I would guess that
 28 that I would like to see it tripled in the next five



1 COMMISSIONER FIRESTONE: From one million
2 to three million per annum over a period of five years?

3 DR. HOFFER: Yes.

4 COMMISSIONER FIRESTONE: Would you say,
5 sir, that if we were to increase the grants and the
6 expenditures on research, say with next year to two
7 million, that the two million could be spent constructively?

8 DR. HOFFER: Yes Dr. Firestone, I think
9 it could, but there is a condition. I don't think it
10 could be spent constructively if it were merely an
11 increase in the grant system we have today.

12 COMMISSIONER FIRESTONE: Therefore, in
13 order to spend an additional million dollars for say the
14 next year or two, and perhaps three million in five
15 years, we would have to change our grant system?

16 DR. HOFFER: That is right.

17 COMMISSIONER FIRESTONE: What particular
18 grants would you attach a high priority to under that
19 changed sort of system?

20 DR. HOFFER: Well, I think talking in
21 terms of our own needs in Saskatchewan, I would like
22 to see a much larger block grant given to our Government,
23 that would be an annual grant.

24 COMMISSIONER FIRESTONE: That would be
25 an annual grant from the Federal Government to the
26 Government of Saskatchewan, for use in psychiatric
27 research. It would be a specific grant?

28 DR. HOFFER: That is right.

29 COMMISSIONER FIRESTONE: With no con-
30 ditions attached?



COMMITTEE

DR. ROBERT: Yes.

COMMISSIONER FIRESTONE: Would you say,

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expenditures on research, say with next year to two

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1 DR. HOFFER: No, I would say there should
2 be conditions attached.

3 COMMISSIONER FIRESTONE: What conditions?

4 DR. HOFFER: One, that it be used for
5 psychiatric research. The second condition which I
6 think would be wise, that there ought to be no cut
7 back in the present psychiatric research program.

8 COMMISSIONER FIRESTONE: In other words,
9 you would want to make sure that whatever additional
10 funds were made available, they would in fact be in
11 addition to the total funds made available for research,
12 and not to replace grants that might have been made in
13 the past?

14 DR. HOFFER: That is right.

15 COMMISSIONER FIRESTONE: How do you feel,
16 Dr. Hoffer, on the subject of grants to scholars and
17 grants to universities?

18 DR. HOFFER: Well, I think sir, that
19 the universities ought to receive research grants, but
20 again not in the form of the type of grants we have to-
21 day. I think that the University Professors who are
22 interested in doing research have a right to know what
23 their annual budget would be for research. I would
24 like to see the research scientists at our University
25 have this right, and know that they are getting this
26 money every year.

27 COMMISSIONER FIRESTONE: Well, in making
28 such grants would you visualize these grants be made
29 to individual scholars for certain research programs,
30 or to the University to distribute as it sees fit?



DR. HOTTER: No, I would say there should

be conditions attached.

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psychiatric research. The second condition which I

think would be wise, that there ought to be no cut

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interested in doing research have a right to know what

their annual budget would be for research. I would

like to see the research scientists at our University

have this right, and know that they are getting this

money every year.

COMMISSIONER FIRSTONE: Well, in making

such grants would you visualize some grants be made

for research in the field of the history of the

mind, or in the field of the history of the



1 DR. HOFFER: Well, I think that is a
2 very difficult question. I would like to see both
3 aspects treated, because even though individual scholars
4 receive research grants, the universities have to ad-
5 minister them for them, and some universities will
6 charge as much as 30% above the grant for administration.
7 They are using certain basic facilities which have
8 not been taken into account by the grant.

9 COMMISSIONER FIRESTONE: Paragraph 3,
10 page 73 of your very fine brief, Dr. Hoffer, you include
11 a forecast of the position of research workers in the
12 field of psychiatry twenty years from now, and you have
13 qualified your forecast, like all forecasters do,
14 that you may be a little out, or you may be a little
15 wrong, but this seems to be the experience of every-
16 one in this kind of category. Now, sir, you say you
17 anticipate twenty years from now that research workers
18 will still have difficulty getting adequate financial
19 support. Assuming your proposal of an eighteen
20 million dollar research program is realized twenty
21 years from now, would your forecast still hold?

22 DR. HOFFER: No, as you can guess,
23 I was rather pessimistic as regards my proposal being
24 accepted.

25 COMMISSIONER FIRESTONE: Well, sir,
26 you have given the Commission this in terms of a
27 desirable objective, and you have been giving
28 reasons, so can we perhaps defer your pessimism to a
29 later date? Thank you very much.

30 THE CHAIRMAN: Thank you again, Dr. Hoffer.



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later date? Thank you very much.



1 this will be a very valuable document to us, and your
2 views today as well.

3 Now we will proceed with the submission
4 of the Saskatchewan Pharmaceutical Association, and
5 this will be Exhibit number 88.

6 --- EXHIBIT No. 88: Submission by the Saskatchewan
7 Pharmaceutical Association.

8 THE SECRETARY: The Association has
9 also submitted a supplementary document, an Interim
10 Report on a study of pharmacy in Saskatchewan which
11 will be Exhibit number 88A, sir.

12
13 --- EXHIBIT No. 88A: An Interim Report on a
14 Study of Pharmacy in
15 Saskatchewan, dated August
16 the 4th, 1961.

17 SUBMISSION OF THE SASKATCHEWAN PHARMACEUTICAL
18 ASSOCIATION

19 APPEARANCES:

20 Mr. A. Pepper - President

21 Mr. S.E. Ramsey - Vice-President

22 Mr. V. Jansen - Registrar

23
24 MR. PEPPER: Mr. Chairman and Members
25 of the Commission, on behalf of the members of our
26 Association we thank you for the privilege of meeting
27 with you today. May we add our word of welcome to you
28 as well, and we sincerely hope that your visit in
29 Saskatchewan may add some helpful information and
30 suggestions.



1 We appear before you today because the
2 members of our Association believe that the best possible
3 health care should be made available to our people and
4 that our attitude should be one of co-operation in every
5 area of health service and, of course, to ensure that
6 our own part of the program is adequately fulfilled by
7 the provision of pharmaceutical services.

8 The members of the Commission will be
9 aware that the Canadian Pharmaceutical Association, of
10 which we are members, has submitted a preliminary
11 statement and will appear before the Commission at a later
12 date. The Committee appointed to prepare and present
13 the views of the Canadian Pharmaceutical Association
14 has conferred with each provincial association and we,
15 in Saskatchewan, are in agreement with the principal
16 points of that submission.

17 In our submission, which is now before
18 you, we outline the organization and functions of the
19 Saskatchewan Pharmaceutical Association and the program
20 administered by the Association. Appendix B, a
21 statement by the Dean of our College of Pharmacy, in-
22 dicates the educational requirements for a pharmacist.

23 We have attempted to indicate that we
24 believe health care in general should be a personal
25 responsibility, that citizens can band together in
26 voluntary groups, of which there are many in Canada and
27 work out methods of sharing the cost of health care in
28 such a way that none are overburdened with expense.
29 We have indicated that the role of government in health
30 care, in addition to services now provided by most

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work out methods of sharing the cost of health care in

such a way that none are overwhelmed with expense.

We have indicated that the role of government in health

care, in addition to services now provided by



1 governments, should be to encourage the practice of
2 voluntary groups negotiating their own arrangements
3 for each area of health care and that government should
4 also be prepared to contribute some funds to allow the
5 so-called "poor risks" to participate in such plans.

6 We suggest that priority be given to the
7 provision of health care to citizens who encounter
8 difficulty in arranging their own program, that the
9 provision of all aspects of health care to that group
10 be arranged before consideration is given to any plan
11 which would embrace all of our citizens.

12 We have suggested to the Commission that
13 a consumer survey in representative areas of Canada
14 would reveal the needs of our citizens in the matter of
15 health care.

16 We are naturally interested in the
17 provision of pharmaceutical services. We have indicated
18 our belief that the provision of such services is
19 adequate to meet the needs of the citizens and have
20 shown the cost of such services in this area. We have
21 also indicated that, in our experience, there are
22 people, other than those who already receive such
23 services at public expense, who have difficulty in
24 providing themselves with pharmaceutical services. It
25 is in this area that we believe government can encourage
26 the formation of voluntary prepaid prescription plans
27 by contributions which would enable these people to
28 participate.

29 We have stated that the successful
30 operation of health care plans requires negotiation



1 between the provider and the receiver of each service
2 and that the terms must be satisfactory to all con-
3 cerned. In discussing pharmaceutical benefits we have
4 indicated some of the main factors which would apply to
5 the provision of adequate pharmaceutical services.

6 Those are our main points, Mr. Chairman,
7 we will try to answer any questions you may have, and
8 we assure you of our desire to co-operate with this
9 Commission.

10 THE CHAIRMAN: Has Mr. Ramsey or
11 Mr. Jansen anything further to add now?

12 MR. PEPPER: Not at this time sir.

13 COMMISSIONER VAN WART: Just for
14 information, is the practice of code prescription
15 used in this Province at all?

16 MR. PEPPER: No, it does not exist.
17 as far as we know.

18 COMMISSIONER VAN WART: In your summary,
19 number 8, on page 4 of the summary: "This Association
20 does not favour deterrent fees on prescriptions but
21 a cost sharing plan may be necessary---". Would you
22 elaborate a little on the cost sharing plan you have in
23 mind?

24 MR. PEPPER: Yes Mr. Commissioner.
25 We draw on our own experience in the Province of
26 Saskatchewan, whereby the Government provides service
27 for its wards, I think is the proper term. Initially,
28 this program began, my first experience with it was
29 just when I came out of the Services, it was in
30 operation at that time and provided practically all



1 prescriptions free of charge to the old age pension
2 group. Costs did rise considerably, and a few years
3 later it became necessary to add a deterrent fee of
4 20% . Costs continued to rise, and the deterrent fee
5 was increased to 50%, so the result is today the
6 pensioner pays half of the cost and we bill the remainder
7 to the medical services, and on the basis of that
8 experience we feel that because we do not have a great
9 knowledge of what would happen in a prepaid prescription
10 plan, we feel any deterrent fees should be introduced
11 at the outset, with the possibility that with experience
12 they could be removed entirely, in time.

2
13 COMMISSIONER VAN WART: Following
14 along on the summary, page 5, section (g), the last
15 sentence: "In the light of the experience of other
16 countries with the provision of pharmaceutical services
17 we suggest that there would be an upward trend in
18 utilization which would increase the cost". That is
19 if the plan came into effect?

20 MR. PEPPER: Yes.

21 COMMISSIONER VAN WART: Would that be
22 a substantial increase, or have you any idea?

23 MR. PEPPER: I am sorry, I cannot quote
24 you any accurate figures. We did look at a number
25 of plans. The one that comes to mind was in Great
26 Britain, and again I cannot quote you the figures,
27 but you may recall that it became necessary there to
28 add on deterrent fee. I think initially it was one
29 shilling for one prescription sheet as it could be
30 called, which might contain one to three prescriptions,



1 and later on it was increased to one shilling per
2 prescription. I do know there was an increase in the
3 total cost of prescriptions, but I cannot quote the
4 figures.

5 COMMISSIONER VAN WART: In page 14 of
6 the brief, at section X (b), you state that: "---- the
7 World Health Organization summary on pharmaceutical
8 benefits and medical care plans quotes most of these
9 as ten percent of the total health care expenditure
10 devoted to drugs". And you continue on on the next
11 page to say: "---that the Canadian figure is less than
12 10% ". And then you bring up the new Green Shield
13 plan. For the record, would you mind stating what the
14 Green Shield plan is?

15 MR. PEPPER: It is one form in Windsor,
16 Ontario. It has a limited number of participants,
17 and has experienced some financial difficulty in operating.
18 Their prescription costs run to about double the
19 Dominion average.

20 COMMISSIONER VAN WART: You mention
21 this 20% per health dollar.

22 MR. PEPPER: Yes.

23 COMMISSIONER VAN WART: Would you
24 visualize that that may be the trend, that the plans
25 would increase, or were less than 10% at the present
26 time, to a much higher figure if one comes in?

27 MR. PEPPER: Yes, but not to the extent
28 of the experience of the Green Shield plan, because,
29 as I stated, with a limited number of participants it
30 would appear that they are loaded with the higher risk



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total cost of prescription, but I cannot quote the

COMMISSIONER VAN WART: In page 14 of

World Health Organization survey on pharmaceutical
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in the United States. At the same time on the part

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MR. WART: In the case of the
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1 groups. They had to raise their fees at one time,
2 and at that time they thought it necessary to give the
3 participants the opportunity of stepping out if they
4 wished, and some of them did, with the results that
5 the average costs rose again.

6 COMMISSIONER VAN WART: Recognizing
7 that the cost would increase, would you still be in
8 the position of not favouring some deterrent?

9 MR. PEPPER: Well, not favouring a
10 deterrent is our general view of the thing, and yet
11 from a practical outlook we feel that there would have
12 to be some at the start.

13 THE CHAIRMAN: What is the real
14 difference between calling it a deterrent and a cost
15 sharing arrangement?

16 MR. PEPPER: Yes, I think it amounts to
17 the same thing, whatever you call it. I think deterrent
18 is a kind of a naughty word.

19 THE CHAIRMAN: Cost sharing is a new
20 expression.

21 COMMISSIONER VAN WART: It has not got
22 dirty yet.

23 THE CHAIRMAN: You speak of the Green
24 Shield plan in Windsor. Have you had an opportunity
25 to study the co-operative plan in the State of
26 Washington at Seattle?

27 MR. PEPPER: No.

28 THE CHAIRMAN: You are not familiar
29 with it?

30 MR. PEPPER: I am not familiar with that,



1 sorry.

2 THE CHAIRMAN: Are you in a position
3 to give us a reasonably accurate figure of the cost of
4 prescription drugs in Saskatchewan in any twelve month
5 period?

6 MR. PEPPER: We have estimates running
7 from \$7,000,000.00 to eight and a half million.

8 THE CHAIRMAN: That is roughly from
9 \$7, to \$8.50 per capita?

10 MR. PEPPER: Yes.

11 THE CHAIRMAN: Are you in a position
12 to give an estimate on the cost of non-prescription
13 drugs --- that is, the over the counter sale of drugs?

14 MR. PEPPER: We haven't been able to
15 arrive at any reasonable figure at all. We estimate
16 it is about half of the cost of the prescribed drugs,
17 but this is just an estimate based on the impression
18 of retail druggists.

19 THE CHAIRMAN: And besides the druggists
20 these things are sold in many other places?

21 MR. PEPPER: In other places as well.

22 COMMISSIONER VAN WART: On your summary,
23 page 6, number III, the last sentence, you state that
24 you are in favour of voluntary plans; that is your
25 position?

26 MR. PEPPER: Yes.

27 COMMISSIONER VAN WART: And then, if
28 you turn to page 14, section 10, you elaborate somewhat
29 on your voluntary prepaid prescription plan based on
30 the contributions plus a grant from the public purse,



copy.

INTERVIEW: Are you in a position

to give us a reasonably accurate figure of the cost of
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to give an estimate on the cost of non-prescription
drugs -- that is, the over the counter sale of drugs?
MR. PAPER: We haven't been able to
arrive at any reasonable figure at all. We estimate
it is about half of the cost of the prescribed drugs,
and this is just an estimate based on the impression
of retail druggists.

THE CHAIRMAN: How would you estimate the drug cost

these drugs are sold in many other places?

MR. PAPER: In other places as well.

COMMISSIONER VAN WART: On your summary,

page 6, number 11, the last sentence you state that

you are in favour of voluntary plans; that is your

position?

COMMISSIONER VAN WART: And then, is

you turn to page 14, section 10, you elaborate somewhat
on your voluntary unpaid prescription plan based on
contributions plus a grant from the public purse,



1 and then in your submission known as Exhibit 88A, you
2 suggest that these be brought in by phases: one, two
3 and three phases?

4 MR. PEPPER: Yes.

5 COMMISSIONER VAN WART: Would you
6 elaborate slightly for the benefit of the Commission
7 your ideas on these phases of introduction?

8 MR. PEPPER: Yes, Mr. Chairman, and
9 Mr. Commissioner: I might say the Exhibit you have
10 before you is a result of discussions with the Provincial
11 Health Department as to what manner we could work to-
12 gether to provide these services, and we felt that be-
13 cause there is no real basis of operation we will be
14 working in the dark to some extent, and we should add
15 these benefits gradually.

16 We felt the first phase should be the
17 addition of all drugs to a hospital care program inasmuch
18 as people are of the opinion they do have a prepaid
19 hospital care program, and we think it should be in-
20 clusive of all drugs.

21 Then we turn to the people we feel are
22 not able to adequately provide themselves with drugs
23 -- this is on page 16. This was worked out merely
24 as an example and not as a plan which should actually
25 take place. We try to point out there are certain
26 conditions which require more medication than others,
27 and perhaps if the Government wished to add these as
28 benefits. It may be easier to add certain drugs
29 for certain conditions rather than opening the entire
30 field of drugs, which could be a very, very costly affair.

and then in your submission known as Exhibit 88A, you suggest that these be brought in by phases - one, two, and three phases?

COMMISSIONER VAN WART: Would you

elaborate slightly for the benefit of the Commission your ideas on these phases of introduction?

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gether to provide these services, and we felt that be-

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clusive of all drugs.

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conditions which require more medication than others,

and perhaps if the Government wished to add these as

benefits. It may be easier to add certain drugs

for certain conditions rather than opening the entire

field of drugs, which could be a very, very costly affair



1 You will notice phase 3 was merely to
2 remove the 50% fee from those who are now receiving
3 some help, and up to this point we felt their services
4 would be on an equal basis with other people, and it
5 would not be necessary to change their status until
6 some of the other people had been covered.

7 Am I providing what you are after?

8 COMMISSIONER VAN WART: Yes. Has the
9 Government brought into effect phase number 1 as yet?

10 MR. PEPPER: No. I should correct myself:
11 this was a discussion with the Thompson Committee, and
12 not with the Government as such; and these were our
13 suggestions.

14 COMMISSIONER VAN WART: Another matter
15 on page 18 of your brief, section(h), the third part,
16 you bring out in these items affecting drug prices,
17 and these items that you have mentioned here are
18 governmental factors which affect the prices of drugs:
19 For example, you state that 11% sales tax is on drugs.
20 You also state that a high duty on finished drugs which
21 are imported --- is that a very large item, or is it
22 only on a few items?

23 MR. PEPPER: I would put it this way,
24 that there are -- oh, about the number of imported ones?

25 COMMISSIONER VAN WART: Yes.

26 MR. PEPPER: I really don't know. We
27 tried to pick this out of the Restrictive Trade
28 Practices hearings and didn't make a very good job of
29 it.

30 COMMISSIONER VAN WART: But it does exist?



1 MR. PEPPER: Yes.

2 COMMISSIONER VAN WART: The third item :
3 "Retail Pharmacies do not have access to the same price
4 ranges as governments and hospitals." That is to say,
5 you are saying retail drugs cost more than what the
6 Government pays for drugs?

7 MR. PEPPER: This is so.

8 COMMISSIONER VAN WART: Is that a very
9 large discrepancy?

10 MR. PEPPER: In some cases there are.
11 One thing that comes to mind is a cortisone preparation
12 which costs us, I think, \$17.00, and we heard price
13 quotations ranging all the way from -- when I say
14 \$17.00, I mean \$17.00 per one hundred -- and we heard
15 price quotations ranging all the way from \$1.95 to \$7.00
16 as the hospital price. So, there is quite a wide
17 difference. I don't suggest this applies to all drugs.
18 We don't really know that.

19 COMMISSIONER VAN WART: Does this range
20 over a large number of items, or just on a few items?

21 MR. PEPPER: I think it is more likely
22 to be over a smaller number of items which are in wide
23 use. I think you will know there are many items that
24 a hospital possibly wouldn't have in any larger quantities
25 than any retail pharmacy, and I think there they would
26 be very much the same price range as we have, and there
27 would be no point in asking for tenders on that type of
28 quantity; but in the large items there is a vast difference.

29 COMMISSIONER GIRARD: Mr. Pepper,
30 on Summary 4 and also on page 16 it is noted that hospital



the third item :
"Retail Pharmacies do not have access to the same price
ranges as governments and hospitals." That is to say,
you are saying retail drugs cost more than what the
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wide range?
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would be no point in saving for tenders on that type of
no summary # and also on page 16 it is noted that hospital



1 pharmacies are dispensing only for their in-patients:

2 What would you do with the personal help service in a
3 hospital?

4 MR. PEPPER: With the people who work
5 in a hospital?

6 COMMISSIONER GIRARD: Yes, the personal
7 help service --- employees of the hospital?

8 MR. PEPPER: We have never quarreled
9 with that. We didn't even consider that part of it.

10 COMMISSIONER GIRARD: You would include
11 them with the in-patients?

12 MR. PEPPER: We would take it that they
13 would get the same benefits as the in-patients. We
14 have accepted this.

15 COMMISSIONER GIRARD: But you would not
16 go so far as to say all the employees of the hospital ---

17 MR. PEPPER: All the employees?

18 COMMISSIONER GIRARD: Yes, I am talking
19 about the employees when they go to the health service
20 when they are ill; but supposing they do not go through
21 the health service of the hospital, they would still be
22 able to purchase their drugs?

23 MR. PEPPER: Frankly, we haven't examined
24 that facet. We knew it existed, and let it be.

25 COMMISSIONER GIRARD: I ask you this
26 because there has been some controversy about this in
27 my Province in the hospitals some time ago, and there
28 were divergent opinions.

29 MR. PEPPER: I think any prescription
30 drugs that are prescribed in the hospital for a member of



What would you do with the personnel help service in a hospital?

MR. PETER: With the people who work

help service -- employees of the hospital?

With that, we didn't ever consider that part of it.

What would include that? You would include them with the hospital?

MR. PETER: We would take it that they

would get the same benefits as the hospital. We

have accepted that.

CONCERNING CHAIR: But you would not

go so far as to say all the employees of the hospital --

MR. PETER: All the employees?

CONCERNING CHAIR: Yes, I am talking

about the employees when they go to the health service

when they are ill; but regarding going to not go through

the health service of the hospital. They would still be

able to purchase their drugs.

That fact, we knew it existed, and let it be.

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because there has been some controversy about this in

my Province as to the hospitals some time ago, and there

were divergent opinions.

MR. PETER: I think any prescription

drugs that are prescribed in the hospital for a member of



1 the staff -- it seems to be a courtesy that has been
2 extended to staffs in general by any employer, that
3 the staff get a bit of benefit in their purchases.
4 I don't think it should extend beyond the prescription
5 drugs. I don't think they should be allowed to go and
6 buy them on their own.

7 COMMISSIONER GIRARD: In Summary 3,
8 para 4, that all prescriptions be dispensed only by
9 pharmacists ---

10 THE CHAIRMAN: Excuse me, Miss Girard,
11 with your permission: You were saying you wanted it
12 restricted to in-patients and employees; why not the
13 out-patients who come to the out-patient department of
14 the hospital?

15 MR. PEPPER: We have always considered
16 that an out-patient is the same as the patient going to
17 a doctor in a clinic downtown rather than the clinic
18 in the hospital.

19 COMMISSIONER FIRESTONE: Might you not
20 encourage in such a case the doctor to put a patient
21 into a bed instead of treating him in the out-patient
22 part in order to make it easier for him to get his
23 drugs?

24 MR. PEPPER: I would not have thought
25 it would be worth the effort as far as cost is concerned.

26 COMMISSIONER FIRESTONE: It has been
27 presented to us in other provinces that this has been
28 the case in some rural areas.

29 MR. PEPPER: I see.

30 COMMISSIONER GIRARD: Summary 3, paragraph



the staff -- it seems to be a courtesy that has been extended to staffs in general by any employer, that the staff get a bit of benefit in their purchases. I don't think it should extend beyond the prescription drugs. I don't think they should be allowed to go and buy them on their own.

COMMISSIONER CHAND: In Summary 5.

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MR. REPPER: We have always considered that an out-patient is the same as the patient going to a doctor in a clinic downtown rather than the clinic in the hospital.

encourage in such a case the doctor to put a patient into a bed instead of leaving him in the out-patient ward in order to make it easier for him to get his drugs?

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COMMISSIONER CHAND: It has been presented to us in other provinces that this has been the case in some rural areas.

MR. REPPER: I see.



1 4, "That all prescriptions be dispensed only by pharmacists.

2 You mean you exclude patent medicines?

3 MR. PEPPER: Excluding patents, yes.

4 COMMISSIONER GIRARD: I was thinking
5 again of the hospital pharmacy where you have the
6 licensed pharmacist and maybe an apprentice or student
7 in the pharmacy and some other aides.

8 MR. PEPPER: We take the attitude when
9 an apprentice dispenses he dispenses only under the
10 supervision of the pharmacist.

11 COMMISSIONER GIRARD: Even if the
12 pharmacist is not bodily there at the moment?

13 MR. PEPPER: Yes, that could be.

14 THE CHAIRMAN: I think the hospital
15 pharmacists will be dealing with that in their own
16 presentation.

17 COMMISSIONER BALTZAN: Mr. Pepper and
18 gentlemen, you are aware that in other countries where
19 they have comprehensive, all inclusive services, that
20 there is a deterrent fee on prescriptions?

21 MR. PEPPER: Yes.

22 COMMISSIONER BALTZAN: And then somewhere
23 later on I read that in Saskatchewan there is an extra
24 personal charge for some prescriptions. I might say,
25 speaking about terms in the United States of America
26 they seem to call a spade a spade, and they use the
27 word "abuses" instead of such camouflaged terms,
28 as "deterrents" and "utilization fees". Would you
29 care to commit yourself on question 1: these things
30 happening, this use of prescriptions because of abuses.



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licensed pharmacist and maybe an apprentice or student
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an apprentice pharmacist is dispensed only under the
supervision of the pharmacist.

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COMMISSIONER BATTIN: Mr. Pepper and

Gentlemen, you are aware that in other countries where
they have comprehensive, all inclusive services that
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MR. PERLIN: Yes.

COMMISSIONER BATTIN: And then sometimes

letter on I read that in Washington there is an extra
personal charge for a prescription. I might say,

speaking about terms in the United States of America

they seem to call a grade a space, and they use the

word "obscure" instead of such camouflaged terms.

as "deterrents" and "utilization fees". Would you

care to commit yourself on question 1: these things

happening, this use of prescriptions because of abuses



1 due to a free listing of these drugs?

2 MR. PEPPER: I am not inclined ---

3 COMMISSIONER BALTZAN: You don't need to
4 commit yourself.

5 MR. PEPPER: I am not inclined to think
6 there are many abuses, that the reason for the increased
7 cost that we mentioned in our Saskatchewan plan was that
8 people became gradually aware of the benefits they could
9 derive from this plan and began to make use of them,
10 and I don't think for a minute it was a frivolous use
11 at all. I think these were people who had refrained from
12 seeking medical attention or refrained from getting
13 prescriptions because they didn't feel they could afford
14 them.

15 COMMISSIONER BALTZAN: We will come back
16 to that a little later. Have costs of compounded
17 prescriptions in the old fashion way, rather than in
18 capsules and pills, risen because of the increased high
19 rents, salaries and other services rather than the in-
20 crease in the basic costs of the ingredients used, as
21 for instance Belladonna et cetera?

22 MR. PEPPER: This is so. I might say
23 on Belladonna it is possible the price has doubled
24 in the course of 25 years, which still does not con-
25 stitute a very great cost. But the costs of the service
26 have increased materially: for instance, 30 years ago,
27 \$25.00 a week was quite an adequate salary for a
28 pharmacist. Today it is more in the nature of \$125.
29 And also, rents as you suggest. The total cost of
30 doing business has appreciably increased.



COMMISSIONER BALTMAN: You don't need to

MR. HEPER: I am not inclined to think

there are many cases, that the reason for the increased cost that we mentioned in our Saskatchewan plan was that people became gradually aware of the benefits they could derive from this plan and began to make use of them, and I don't think for a minute it was a frivolous use at all. I think these were people who had refrained from seeking medical attention or refrained from getting prescriptions because they didn't feel they could afford them.

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prescriptions in the old fashion way, rather than in capsules and pills, risen because of the increased light, salaries and other services rather than the increase in the basic costs of the ingredients used, as for instance Belladonna et cetera?

MR. HEPER: This is so. I might say

on Belladonna it is possible the price has doubled in the course of 25 years, which still does not constitute a very great cost. But the costs of the service have increased materially; for instance, 30 years ago, \$25.00 a week was paid an adequate salary for a pharmacist. Today it is more in the nature of \$125. And also, rents as you suggest. The total cost of



1 COMMISSIONER BALTZAN: That has increased
2 the cost of the people?

3 MR. PEPPER: This is so, yes.

4 COMMISSIONER BALTZAN: Gentlemen, I
5 want to turn to your Appendix and be comforted I am not
6 a surgeon. Appendix A 4, paragraphs 22, 23 and 24:
7 "As experience was gained it was felt necessary in 1948
8 to introduce a utilization fee", and so, on December the
9 1st, it went up 20%, and on April the 1st the 20% payment
10 by the beneficiary was increased to 50%. My question is,
11 who saw fit to impose this personal cost or utilization,
12 or whatever term you want to apply -- this increase,
13 especially on ~~the~~ beneficiaries who had provision, who
14 had considered the fact they needed subsidization, or
15 they needed help from outside sources. Who made that
16 change? Was it the pharmacists? Was it the profession?
17 Was it the government?

18 MR. PEPPER: In each case we were asked
19 to meet with representatives of the Medical Services
20 Division who discussed their problems, laid out their
21 problems ---

22 COMMISSIONER BALTZAN: Excuse me: "Medical
23 Services"?

24 MR. PEPPER: Medical Services Division
25 of the Department of Public Health.

26 COMMISSIONER BALTZAN: Yes, I see.

27 MR. PEPPER: And they laid out their
28 problems to the representatives of the Pharmaceutical
29 Association, explained that costs had gone beyond their
30 budget and asked our cooperation in collecting this fee.



1 COMMISSIONER BALTZAN: In collecting ...?

2 MR. PEPPER: In collecting the portion
3 of the cost from the patient.

4 COMMISSIONER BALTZAN: So that it came
5 because the load was heavy on government?

6 MR. PEPPER: Yes.

7 COMMISSIONER BALTZAN: Or departments
8 of government?

9 MR. PEPPER: This is so.

10 COMMISSIONER BALTZAN: On page A7 of the
11 Appendix --- and this is a very long Appendix but a
12 healthy one --- 34-A, "The advent of the so-called tran-
13 quilizers has resulted in them finding a prominent
14 place in the therapy prescribed for Medical Services
15 Division beneficiaries", but you note very interestingly
16 that since the percentage of prescriptions affecting the
17 nervous system as a function of the total has not
18 changed appreciably for the past several years that it
19 is assumed that these are being used in place of other
20 types of sedatives such as barbiturates. I must say
21 having listened to other questions on the same problem
22 before, this is a very valuable bit of information,
23 and I would say important and creditable to Saskatchewan.
24 In reading magazine reports and opinions given every-
25 where, the tranquilizer and other sedative drugs are
26 on the increase, and here you say that they have re-
27 mained relatively the same over the past several years?

28 MR. PEPPER: Yes. May I add, Mr.
29 Commissioner, I think you will have noted that the
30 Appendix A is a copy of an address delivered to our



Appendix A as a copy of an address delivered to our

Commissioner, I think you will have seen that the

MR. PRYOR: Yes, May I add, Mr.

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COMMISSIONER BATTAN: On page 47 of the

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MR. PRYOR: In collecting the portion

COMMISSIONER BATTAN: In collecting ...?



1 Association by the Pharmacists' Supervisor of the
2 Medical Services Division, but nevertheless our ex-
3 perience seems to bear out what he has stated.

4 COMMISSIONER BALTZAN: That is the
5 reason why I want to put it on record. Appendix A8,
6 38-A: "While the tendency has been for the cost of
7 individual preparations to remain fairly stable or even
8 reduce in price, many drugs in recent years have a
9 relatively short popularity."

10 Due to perhaps fads, advertising,
11 calling popular attention to such things that are short
12 lived but in popular articles in published journals,
13 I mean, you seem to have a transitory period where there
14 is a great demand for new drugs that do not live long.

15 MR. PEPPER: They do not perform what they
16 were intended to perform.

17 COMMISSIONER BALTZAN: They are soon
18 superseded by new drugs?

19 MR. PEPPER: Yes.

20 COMMISSIONER BALTZAN: Secondly, you say
21 that there is an increase from 1.56 dollars in 1949 - 50
22 to 2.73 dollars in 1958-59 which leaves a 75% increase.
23 Is that because you are stocked up with some of these
24 things that go out of fashion or what is that?

25 MR. PEPPER: No, the increase is re-
26 presented, I think, in the use of the more costly
27 drugs. We do have the problem you mentioned of having
28 stocked up with drugs that are no longer in use, however,
29 that problem is ours and it is not reflected in the
30 price of the prescriptions.

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38-A: "While the tendency has been for the cost of

individual preparations to remain fairly stable or even

reduce in price, many drugs in recent years have a

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Has the passage been, supervising

calling popular attention to some extent that are short

lived but in popular articles in medical journals.

I mean, you seem to have a fairly long period where there

is a great demand for new drugs and then it is long.

MR. PERLIN: They do not perform what they

FROM 2010-1950: They are soon

superseded by new drugs?

MR. PERLIN: Yes.

that there is an increase from 1 to 2 dollars in 1950 - 50

to 2 1/2 dollars in 1950-55 which leaves a 50% increase.

Is that correct and are you looking up with some of these

things that go out of fashion or what is that?

MR. PERLIN: No, the increase is 10-

drugs. We do have the problem you mentioned of having

stocked up with drugs that are no longer in use, however,

that problem is ours and it is not reflected in the

price of the prescriptions.



1 COMMISSIONER BALTZAN: The last line in
2 the first paragraph on A-9 a very interesting statement
3 is made:

4 "The vitamin group involved a cost which was
5 on 14.6% of the total and the cardiovascular
6 drugs cost 13.7% of the total".

7 This is really not a pharmaceutical
8 question, more perhaps a medical question, but do you
9 think the vitamins today as they are being prescribed
10 are taking the place of the old fashion tonics that
11 people used to buy over the counter?

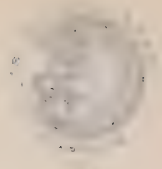
12 MR. PEPPER: That is so, yes.

13 COMMISSIONER BALTZAN: And it is due to
14 to that, as much or perhaps even more than the fact
15 that this population in this area is so short of the
16 vital vitamins?

17 MR. PEPPER: I think that reflects
18 in the age group of which we were speaking here, this
19 is the people over 65 and I doubt if these figures would
20 reach the same proportion if it was taken out against
21 the entire population.

22 COMMISSIONER BALTZAN: In other words,
23 you have not got a breakdown of the amount of
24 utilization of the younger age portion of this population
25 using vitamins compared with the older population?

26 MR. PEPPER: May I put it this way:
27 This group does include also some of the very young
28 represented by the mothers in our groups so the very
29 young and the very old. I am sorry to use the term
30 "very old" but that is the intention there.



COMMISSIONER

the first paragraph on A-9 a very interesting statement

"The vitamin group involved a case which was
on 14.6% of the total and the carotene
group cost 13.7% of the total."

This is really not a pharmaceutical

question, and perhaps a medical question, but at the
time the vitamins today as they are being prescribed
are taking the place of the old vitamin pills that
people used to buy over the counter.

COMMISSIONER: BAHAMAS: And it is due to

so that as much as possible even more than the fact
that this population in this area is about 100,000
vital vitamins?

MR. TAPPE: I think that reflects

in the age group of which we were speaking here, this
is the people over 65 and I doubt if these figures would
reach the same proportion if it was taken out again.

COMMISSIONER: BAHAMAS: In other words,

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utilization of the younger age portion of this population
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represented by the mothers in our groups so the very
young and the very old. I am sorry to use the term
"very old" but that is the intention there.



1 COMMISSIONER BALTZAN: According to how
2 one feels?

3 MR. PEPPER: In between we do not have
4 the figures but we do not think it is that high.

5 MR. HALL: Mr. Chairman, before Dr.
6 Firestone starts there was a remark made a few minutes
7 ago about testimony we heard in another province about
8 doctors taking patients to the hospitals so as in-patients
9 they had the cost of drugs paid for. Under that plan,
10 I understand, that costs of drugs prescribed to patients
11 in hospital were paid for under the hospital plan. I
12 do not think that is the case in this Province so this
13 more than likely would not be here. The only difference
14 of being treated as an out-patient would be the difference
15 in the prescription of drugs.

16 COMMISSIONER FIRESTONE: Mr. Pepper,
17 people in Canada complain about the high drug prices;
18 people in Saskatchewan complain about the high drug
19 prices, would you say there is some justification on
20 such complaints?

21 MR. PEPPER: We believe there is some
22 justification, yes.

23 COMMISSIONER FIRESTONE: Could you explain
24 to the Commission what in your opinion are some of the
25 reasons for drug prices to be considered to be high?

26 MR. PEPPER: Well, the reasons which
27 have been stated are that in comparison with other
28 countries they are high. I saw somewhere that if the
29 11% sales tax were removed that the United States and
30 Canadian figures would come a little closer together.



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one feels?

MR. FETTER: In between we do not have
the figures but we do not think it is that high.

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COMMISSIONER WHESTONE: Could you explain
to the Commission what in your opinion are some of the

reasons for drug prices to be considered to be high?
MR. FETTER: Well, the reasons which

have been stated are that in comparison with other
countries they are high. I saw somewhere that if the

1% sales tax were removed from the United States and
Canadian figures would come a little closer together.



1 The only other thing apart from that is perhaps the
2 allocation of the charges made on drugs by the
3 manufacturer. For instance, we discussed a moment
4 ago the prices paid by the retail pharmacists as compared
5 to the prices paid by hospitals and governments. We
6 think this is not a realistic plan but with any lowering
7 of the cost to the retail pharmacists would probably
8 entail an increase in the cost to hospitals and govern-
9 ment plans .

10 COMMISSIONER FIRESTONE: You refer to
11 the example you gave to the Commission a little earlier,
12 you mentioned one drug, can you give us the name of
13 that drug?

14 MR. PEPPER: Yes, prednisone.

15 COMMISSIONER FIRESTONE: Just to be quite
16 clear we are talking about the same thing, you recall
17 you had mentioned to us one drug where the price to the
18 pharmacist would be \$17.00 for one hundred and with
19 hospitals and government departments they would get the
20 same drug for as low a price as \$1.95. The name of
21 that drug was?

22 MR. PEPPER: Prednisone. I might add
23 these are probably contract prices. We took some of
24 those prices and the remarks made by Mr. Frawley in
25 the Restrictive Trade Practices Commission.

26 COMMISSIONER FIRESTONE: I do not know
27 what prednisone is, could you explain to me what kind
28 of drug it is?

29 MR. PEPPER: It is a cortisone preparation
30 used in arthritis or asthmatic conditions.



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allocation of the charges made on drugs by the

manufacturer. For instance, we discussed a moment

ago the prices paid by the retail pharmacists as compared

to the prices paid by hospitals and Government. We

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cause an increase in the cost to hospitals and Govern-

COMMISSIONER FIRSTONE: You refer to

the example you gave to the Commission a little earlier.

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MR. PREPPE: Yes, prednisone.

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pharmacist would be \$17.00 for one hundred and with

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those prices and the remarks made by Mr. Hrawley in

the Restrictive Trade Practices Commission.

COMMISSIONER FIRSTONE: I do not know

what prednisone is, could you explain to me what kind

of drug it is?

used in arthritis or asthmatic conditions.



1 COMMISSIONER FIRESTONE: Is this drug
2 used frequently? Are sales of that type of drug
3 fairly large in terms of quantities?

4 MR. PEPPER: I could not say that it is.
5 It is perhaps one in twenty as far as prescriptions are
6 concerned.

7 COMMISSIONER FIRESTONE: Well, it is
8 an important drug in the field of dealing with arthritic
9 conditions?

10 MR. PEPPER: Yes.

11 COMMISSIONER FIRESTONE: If I understand
12 you correctly the price differential is around --- the
13 figures on the drugs might be as much as \$17. to
14 Government Departments and hospitals \$1.95 or \$2.00;
15 there is a difference between the two of 750%. Now,
16 why would it be possible for the hospital to get a drug
17 for one price and it be necessary for the druggist to
18 pay 750% more for the same drug?

19 MR. PEPPER: I do not know if I can give
20 you a satisfactory explanation of that; I would much
21 prefer that someone else would give me one. The
22 attitude of the manufacturer and this he may be able
23 to justify, is that his prices to hospital involves no
24 promotional material at all, it involves a one shot
25 transaction for a large amount of the drug and it does
26 not usually involve the preparation of small packages.
27 Now, it could - this could justify a certain degree
28 of difference. Then again we have differences in
29 prices as between manufacturers and there is some
30 variation there.



WITNESSES: In this case

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MR. RILEY: I could not say that it is

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COMMISSIONER WITNESSES: Well, it is

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conditions

you correctly the price differential is around - the

figures on the drug might be as much as \$1.00 to

Government Department and Hospital \$1.00 or \$1.50

there is a difference between the two of \$1.00. Now,

why would it be possible for the hospital to pay a drug

for one price and to be necessary for the hospital to

pay 50% more for the same drug?

MR. RILEY: I do not know if I can give

you a satisfactory explanation of that; I would much

prefer that someone else would give me one.

attitude of the manufacturer and this he may be able

to justify. Is that his (as the hospital) answer to

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transaction for a large amount of the drug and is does

not usually involve the preparation of small quantities.

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of difference. Then again we have differences in

prices as between manufacturers and there is some

variation there.



1 COMMISSIONER FIRESTONE: I think you
2 made three points, if I am not mistaken. I will take
3 one point at a time. There may be other points but
4 we will examine these. Your first point was, if I
5 understood you correctly, was it bulk purchasing?

6 MR. PEPPER: Yes.

7 COMMISSIONER FIRESTONE: So that, at
8 all events, one of the points you made would be bulk
9 purchasing?

10 MR. PEPPER: Yes.

11 COMMISSIONER FIRESTONE: And I think the
12 second point was cost of selling?

13 MR. PEPPER: Yes.

14 COMMISSIONER FIRESTONE: Now, would it
15 not be possible for the pharmacists to develop a scheme
16 where they would be in a somewhat similar position to
17 the hospitals whereby they would do their buying co-
18 operatively and have bulk purchasing to be treated on
19 that point the same as the hospitals?

20 MR. PEPPER: Yes. Now, this involves
21 a new approach and that approach was made at one time
22 and we ended up with a one more wholesale operation with
23 the same overhead that applied to any other wholesale
24 and then this particular wholesale will get the same
25 prices as were made available to other wholesales.
26 That did not solve the problem. We have considered
27 attempting to get a bulk purchasing program amongst
28 the druggists of Saskatchewan but there is this about
29 it; first of all, I understand that in Saskatchewan
30 we use 4-1/2% of the drugs used in Canada, not a very



I think you made three points, if I am not mistaken. I will take one point at a time. There may be other points but we will examine these. Your first point was, if I understood you correctly, was it bulk purchasing?

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MR. PETER: Yes. Now, this involves a new approach and that approach was made at one time and we ended up with a one more wholesale operation with the same overhead that applied to any other wholesale and then this particular wholesale will get the same prices as were made available to other wholesalers. That did not solve the problem. We have considered attempting to get a bulk purchasing program amongst the druggists of Saskatchewan but there is this about we use 4.5% of the drugs used in Canada, not a very



1 large amount, at least not large enough to use as a
2 purchasing weapon. . . . There are other factors involved.
3 For instance, we have the narcotic drugs and what we
4 call controlled drugs which cannot be just passed
5 around from one druggist to another or from a bulk
6 depot unless it is licensed as a wholesaler. . . . Then,
7 of course, there is the difficulty of repackaging. . . . I
8 should not say difficulty but the repackaging, and this
9 costs something; shipping costs something also. . . . We
10 have not got beyond that point at this time but we will
11 continue to examine it.

12 COMMISSIONER FIRESTONE: But you would
13 say from your experience that if a scheme of bulk
14 purchasing could be developed prices of drugs could be
15 brought down?

16 MR. PEPPER: . . . We think so.

17 COMMISSIONER FIRESTONE: . . . You also
18 mention that another reason was the cost of selling to
19 a hospital, the advertising, the persuasive literature,
20 et cetera, involves less effort than selling to a pharmacy.
21 Now, is it really true that all that effort is involved
22 in persuading a hospital or persuading the pharmacist
23 to buy or is this effort directed towards the physicians
24 who prescribe the drug?

25 MR. PEPPER: . . . I think you have touched
26 upon a proper point there. . . . The effort involved in
27 selling to a pharmacist is merely writing of an order
28 for the product which is being used.

29 COMMISSIONER FIRESTONE: Exactly, and,
30 therefore, one could not really justify a difference of



large amount, at least not large enough to use as a
 purchasing weapon. There are other factors involved.
 For instance, we have the narcotic drugs and what we
 call controlled drugs which cannot be just passed
 around from one druggist to another or from a bulk
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 in persuading a hospital or persuading the pharmacist
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 who prescribes the drug?

MR. PHILAN: I think you have touched

upon a proper point there. The effort involved in
 selling to a pharmacist is merely writing of an order
 for the product which is being used.

therefore, one could not really justify a difference of



1 750% on account of the sales effort of manufacturers
2 of drugs in persuading pharmacists to buy. You are not
3 suggesting that that is so. You suggested other
4 reasons as well but I think it would be fair to say this
5 main effort is directed towards the physicians who
6 prescribe the drug and the fact remains unanswered,
7 what are some of the basic reasons of a difference of
8 750% on this particular drug?

9 MR. PEPPER: May I say that these are
10 the dramatic expressions we hear about, we really do
11 not know what the difference is in the average drug
12 that is used in an ordinary type.

13 COMMISSIONER FIRESTONE: I quite agree
14 that we do not have the average before us, but I think
15 it is a dramatic type that brings home the problem which
16 we are facing. We as Commissioners are not interested
17 in the statistical exercise on averages, we are interested
18 to learn more about the problem, how large the problem
19 is and what can be done about it.

20 MR. PEPPER: This applies to the
21 druggist, I think, in constant average use.

22 COMMISSIONER FIRESTONE: In other words,
23 you are saying, if I understand you correctly, there is
24 a problem of high drug costs and a good part is beyond
25 the control of the pharmacists in bringing down prices
26 of the drugs. The druggist has his charges and regular
27 fees and he has no choice and he cannot, in fact, influence
28 the retail price of drugs because it is set by his own
29 costs and the fee schedule.

30 MR. PEPPER: This is so. It does not



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not know what the difference is in the average drug
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a problem of high drug costs and a good part is beyond
the control of the pharmacist in bringing down prices
of the drugs. The druggist has his charges and regular
fees and he has no choice and he cannot, in fact, determine
the retail price of drugs because it is set by his own
costs and the fee schedule.

MR. PERPER: This is so. It does not



1 stop us from trying, though.

2 COMMISSIONER FIRESTONE: I am encouraged
3 to hear how you are trying. If on subsequent thought
4 you or your Association has any concrete suggestions
5 to make to the Commission on how drug prices could be
6 brought down with the cooperation of the pharmaceutical
7 profession in Canada we would appreciate such views if
8 you would submit them in writing.

9 MR. PEPPER: If we find them we will
10 certainly write to you.

11 COMMISSIONER FIRESTONE: Now, you say
12 that you are in favour of a prepaid plan for drugs?

13 MR. PEPPER: Yes.

14 COMMISSIONER FIRESTONE: I understand
15 you suggest this be a voluntary plan?

16 MR. PEPPER: Yes.

17 COMMISSIONER FIRESTONE: And you suggest
18 this be advanced, one, through contribution of the
19 drug recipient, and, two, through contribution by
20 government?

21 MR. PEPPER: Right.

22 COMMISSIONER FIRESTONE: Do I take it
23 the contribution of the participants would be in the form
24 of a premium?

25 MR. PEPPER: Yes.

26 COMMISSIONER FIRESTONE: And by govern-
27 ment from general revenue funds, the funds having been
28 raised in the first place through taxation?

29 MR. PEPPER: We cannot be specific with
30 that because we have not any idea of what it would really



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raised in the first place through taxation?

MR. PEPER: We cannot be specific with

that because we have not any idea of what it would really



1 cost.

2 COMMISSIONER FIRESTONE: Yes, we appreciate
3 that but you are in favour of a comprehensive drug plan
4 financed in part by premium payment of those participating
5 in this scheme and in part out of tax revenues?

6 MR. PEPPER: Yes.

7 THE CHAIRMAN: Do you contemplate that
8 would be a separate plan or an adjunct to the physicians'
9 service plan and other aspects?

10 MR. PEPPER: We contemplate it would be
11 an adjunct but it would have to be administered separately.

12 THE CHAIRMAN: Separate funds?

13 MR. PEPPER: Yes.

14 THE CHAIRMAN: Separate bookkeeping?

15 MR. PEPPER: Yes, and separate premiums
16 as well.

17 COMMISSIONER FIRESTONE: I assume you
18 are in favour of the most efficient and most economic
19 system of collection of premiums at one time that can
20 be provided?

21 MR. PEPPER: Yes.

22 COMMISSIONER FIRESTONE: Now, I have a
23 question that relates to paragraph g on page 18 of your
24 submission. You are talking in this paragraph about
25 the possibilities that do exist in reducing drug cost
26 to the consumer and you refer here to the differentiation
27 between brand name drugs and drugs with a generic
28 type name. If I understand you correctly you are
29 stating that in most instances drugs of a generic type
30 are lower priced than drugs of a brand type.



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COMMISSIONER FIRESTONE: Now, I have a

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submission. You are talking in this paragraph about

the possibilities that do exist in reducing drug cost

to the consumer and you refer here to the differentiation

between brand name drugs and drugs with a generic

stating that in most instances drugs of a generic type

are lower priced than drugs of a brand type.



1 MR. PEPPER: It has been so in many cases.

2 COMMISSIONER FIRESTONE: Now, you are
3 also saying that in many instances the generic type
4 drug will be just as effective as a brand type drug?

5 MR. PEPPER: We assume that this will
6 be so. Generic, of course, refers to the name only
7 and we assume this is so on the basis that we would
8 expect some department specifically to set up standards
9 that would ensure that this is so. It may not be
10 necessary so right now.

11 COMMISSIONER FIRESTONE: Well, if you
12 from your experience or your associates from their
13 experience and knowledge of specific drugs which are
14 sold under a brand name and other drugs that are sold
15 under a generic name where there is a substantial price
16 difference, they thing they would have the same thing
17 as far as quality is concerned?

18 MR. PEPPER: Yes.

19 COMMISSIONER FIRESTONE: You are familiar
20 with such types of drugs?

21 MR. PEPPER: Not very many.

22 COMMISSIONER FIRESTONE: But you are
23 familiar with such?

24 MR. PEPPER: Yes.

25 COMMISSIONER FIRESTONE: Perhaps your
26 colleagues might wish to add something to that?

27 MR. RAMSEY: Well, Mr. Commissioner,
28 it appears to me that in the buying of generic named
29 drugs it does not imply that you are going to buy other
30 than a well known brand. It may be prescribed as a



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MR. RAMSEY: Well Mr. Commissioner,

it appears to me that in the paying of generic names

drugs it does not imply that you are going to pay other

than a well known brand. It may be prescribed as a



1 generic name drug, but it depends on the judgment of
2 the pharmacist whether the particular generic named
3 drug which he is considering buying is manufactured by
4 what he considers to be a reputable firm who conduct
5 all phases of checks and examinations at various stages
6 of production, and so on. I think that is a very
7 important aspect of the situation.

8 COMMISSIONER FIRESTONE: Well, I take
9 it that we can rely on the higher caliber of professional
10 ethics of Saskatchewan pharmacists, that they only sell
11 drugs for which they are satisfied with the quality,
12 and that they are drugs from reliable manufacturers,
13 and not from fly-by-nights?

14 MR. PEPPER: This is so.

15 COMMISSIONER FIRESTONE: Well, having
16 accepted this assurance of yours, do I still understand
17 that there are important price differences in certain
18 drugs, some of which have a brand name, and some of
19 which do not, but the ones that are produced without
20 a brand name still being produced by reputable manu-
21 facturers acceptable to you?

22 MR. PEPPER: Yes.

23 COMMISSIONER FIRESTONE: Therefore the
24 problem of making sure, or giving you the confidence
25 that you could sell more of these so-called generic
26 type drugs, and therefore pass on the savings to the
27 people that purchase drugs from you, would be to assure
28 you of the quality of these generic type drugs with the
29 brand type drugs with which you may be more familiar,
30 and the question therefore which it seems to me the

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you of the quality of these generic type drugs with the
brand type drugs with which you may be more familiar,
and the question therefore which it seems to me the



1 pharmacists are facing, and the physician as you outline
2 in paragraph (g), on page 18, is that there should be
3 some method whereby this assurance could be given to
4 the physician and to the pharmacist?

5 MR. PEPPER: This is what we would
6 like.

7 COMMISSIONER FIRESTONE: Now, the
8 question therefore arises, how can such an assurance
9 be passed onto you on a continuing basis, so that you
10 would be buying more and more of what is called the
11 generic type drug, and you are able to pass on more and
12 more of the cost benefits to the person purchasing
13 drugs? How can this idea of yours of increased assurance
14 to the pharmacist and the physician be worked out in
15 practice?

16 MR. PEPPER: May I as a preliminary to
17 answering that state that at the present time we do
18 not have many doctors who prescribe the generic names.
19 All of them prescribe some drugs by generic name. I am
20 satisfied that that would disappear if they too had
21 the assurances that generic name drugs were of a proper
22 caliber. Our suggestion is that the most likely
23 agency to look after this is the Food and Drug Department
24 of the Department of Health, Ottawa. Our understanding
25 is that they have already increased their standards
26 of inspection, but they have not undertaken any methods
27 of licensing importers and producers to the extent that
28 they will be sure that every batch of drugs is of a
29 proper quality.

30 COMMISSIONER BALTZAN: Would you say what



in paragraph (g), on page 18, is that there should be some method whereby this assurance could be given to the physician and to the pharmacist?

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COMMISSIONER BATHAM: Would you say what



1 is the main reason for doctors prescribing trade rather
2 than generic names?

3 MR. PEPPER: I think it is because they
4 want to be sure that they will get the quality of drugs
5 they have been told about.

6 COMMISSIONER BALTZAN: Would you say it
7 is also because the trade name is short and the other
8 may take a whole line?

9 MR. PEPPER: This is so in some cases,
10 not very many.

11 COMMISSIONER FIRESTONE: Would you say
12 that the Saskatchewan Pharmaceutical Association would
13 be in favour of a proposal which would require that the
14 Federal Government licence all drugs imported and
15 manufactured in Canada to ensure that certain minimum
16 standards are observed?

17 MR. PEPPER: Yes, licensed and inspected.

18 COMMISSIONER FIRESTONE: You would
19 therefore be in favour of amendments to existing
20 legislation to achieve this objective?

21 MR. PEPPER: Yes.

22 MR. RAMSEY: Might I add that Dr. Hammond,
23 who is Director of the Food and Drug Act, has made the
24 statement that quality cannot be inspected into a
25 drug. It must depend on the reliability and skill of
26 the manufacturer, and consequently the inspections must
27 be made not only of the finished product itself, but of
28 the type of manufacture and the type of controls that
29 are used in its manufacture. Consequently, in
30 importation of drugs from abroad it would be necessary

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the type of manufacture and the type of controls that

are used in the manufacture. Consequently, in

importation of drugs from abroad it would be necessary



1 for such an organization as we envisage to go abroad
2 and actually inspect and keep a constant check on the
3 factories that desire to import drugs into Canada.

4 COMMISSIONER FIRESTONE: I take it,
5 sir, that assuming that the officials can work out a
6 scheme that is workable and practical, you are in favour
7 of the principle?

8 MR. PEPPER: Definitely. May I add
9 one thing, that at the present time it is not a very
10 high percentage of drugs that really can be prescribed by
11 a generic name, and then we have a further situation,
12 that a number of manufacturers who were producing drugs
13 and marketing them under the generic name only, are
14 gradually acquiring a trade name, if only to the extent
15 of listing their item as the generic name plus the name
16 of their firm, which immediately becomes a trade name.

17 COMMISSIONER FIRESTONE: If I under-
18 stand you correctly, you are not holding a brief whether
19 the particular drug has a trade or generic name. We
20 are mainly interested in the reduced cost of those
21 drugs, and you are in favour, whatever that drug is
22 called, in selling to the people buying drugs from you
23 these drugs at the lowest possible cost, in line with
24 prescribed standards that will satisfy you?

25 MR. PEPPER: This is so.

26 COMMISSIONER FIRESTONE: May I pursue
27 this question a little further as to what can be done
28 to make it easier for physicians and the pharmacists
29 to acquire this knowledge which you feel is necessary,
30 and the assurance which you feel is required in order to



for such an organization as we envisage to go abroad
and actually inspect and keep a constant check on the
factories that desire to import drugs into Canada.

...
...
... that assuming that the officials can work out a
scheme that is workable and practical, you are in favour
of the principle?

...
... one thing, that at the present time it is not a very
high percentage of drugs that really can be prescribed by
a generic name, and then we have a further situation,
that a number of manufacturers who were producing drugs
and marketing them under the generic name only, are
gradually acquiring a trade name. If only to the extent
of listing their item as the generic name plus the name
of their firm, which immediately becomes a trade name.

...
... stand you correctly, you are not holding a belief whatever
the particular drug has a trade or generic name. ...
... are mainly interested in the reduced cost of these
drugs, and you are in favour, whatever that drug is
called, in selling to the people buying drugs from you
these drugs at the lowest possible cost, in line with
prescribed standards that will satisfy you?

MA. PHARM: This is so.

...
... this question a little further as to what can be done
to make it easier for physicians and the pharmacists
to acquire this knowledge which you feel is necessary,
and the assurance which you feel is required in order to



1 be willing to prescribe more drugs of a generic type,
2 presuming that they are lower prices and costs, and I
3 would like to ask you two specific questions. You are
4 in favour of the Federal Government, through the Food
5 and Drug Department to be more active in this field.
6 Would it be possible to obtain such assurances if the
7 Department, as part of its continuing responsibilities,
8 would turn out say a monthly bulletin, which would set
9 out the most recent literature and information providing
10 this assurance on new drugs as they come on the market,
11 and this were made available to all the physicians and
12 pharmacists in Canada, to have an authoritative state-
13 ment, and have that on a continuing basis, to get more
14 people educated that it is not the name of the company
15 necessarily, but it is the type of the drug that really
16 matters?

17 MR. PEPPER: This would be all right,
18 but I think there is a much simpler manner in which it
19 can be accomplished, and that is by merely knowing
20 whether or not a particular firm has been licensed,
21 and meets all the standards required by the provisions
22 of whatever legislation might be required. If we
23 know that firm X meets those standards, then we should
24 be able to accept assurance of all their products.

25 COMMISSIONER FIRESTONE: Would it not
26 be possible that a firm with respect to some drugs
27 is meeting the standards, and not with respect to
28 others?

29 MR. PEPPER: I see your point. You
30 would have to bulletin for each drug. That might be so.



be willing to prescribe more drugs of a generic type,
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would like to ask you two specific questions. You are
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1 COMMISSIONER FIRESTONE: And also the
2 physicians might want to know something about the drugs,
3 rather than about the company. After all, they are
4 prescribing drugs, and they are not interested in
5 helping a company to make a lot of money. They are
6 interested in drugs?

7 MR. PEPPER: Right.

8 COMMISSIONER FIRESTONE: So I understand
9 you would be in support of such a program, which would
10 involve the Department of Health and Welfare through
11 its Food and Drug Department, to make this information
12 available to the physicians and the pharmacists in
13 Canada on a continuing basis?

14 MR. PEPPER: That would be excellent.

15 COMMISSIONER FIRESTONE: Would you also
16 say that since this is more in the form of a bulletin,
17 that people sometimes read and sometimes do not read,
18 would you say that it might be useful if there were
19 an additional service, and that service would be that
20 at the request of any physician or pharmacist there
21 would be a unit within this Department that would
22 answer specific questions, because there must be many
23 cases where questions of doubt arise. Would such an
24 advisory service be helpful, to make it easier to
25 educate both physicians and pharmacists?

26 MR. PEPPER: I would take it for granted
27 that it would be necessary.

28 COMMISSIONER FIRESTONE: You would be
29 in favour of that?

30 MR. PEPPER: Yes sir.



COMMISSIONER FIRESTONE: And also the

physicians might want to know something about the drugs, rather than about the company. After all, they are prescribing drugs, and they are not interested in helping a company to make a lot of money. They are interested in drugs?

COMMISSIONER FIRESTONE: So I understand

you would be in support of such a program, which would involve the Department of Health and Welfare, through its Food and Drug Department, to make this information available to the physicians and the pharmacists in Canada or a continuing basis?

MR. FEEBER: That would be excellent.

COMMISSIONER FIRESTONE: Would you like

say that since this is now in the form of a bulletin, that people sometimes read and sometimes do not read, would you say that it might be useful if there were an additional service, and that service would be that at the request of any physician or pharmacist there would be a unit within this Department that would answer specific questions, because there must be many cases where questions of doubt arise. Would such an advisory service be helpful, to make it easier to educate both physicians and pharmacists?

that it would be necessary.

COMMISSIONER FIRESTONE: You would be

in favour of that?

MR. FEEBER: Yes sir.



1 THE CHAIRMAN: Gentlemen, could you give
2 me a little bit of information about the percentage of
3 prescriptions that are compounded in the retail drug
4 store in Saskatchewan, in terms of the over-all?

5 MR. PEPPER: Just under 10%.

6 THE CHAIRMAN: In the matter of the
7 utilization of the time of a druggist. We have heard
8 a lot about (a) shortage of druggists, (b) the difficulty
9 in recruiting people to the profession, and the cost
10 of a druggist's education. What is the percentage
11 of time that the retail druggist devotes as a druggist,
12 as distinct from the vendor of all other forms of
13 merchandise that we see displayed in drug stores?

14 MR. PEPPER: Less than 50% in most
15 cases. There are some places that you know, where
16 their entire time is taken up.

17 THE CHAIRMAN: Yes, that is true,
18 but I am excluding places like hospital pharmacies and
19 all those kind of things.

20 Thank you very much, gentlemen. We
21 have your submission and it will receive our careful
22 consideration.

23 MR. PEPPER: Thank you, Mr. Chairman,
24 and on behalf of our members, thank you for the hearing.

25 THE CHAIRMAN: We will now adjourn until
26 2:00 o'clock and proceed with the submission of the
27 Canadian Society of Hospital Pharmacists.

28

29 ----LUNCHEON ADJOURNMENT.

30



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and on behalf of our members, thank you for the hearing. THE CHAIRMAN: We will now adjourn until

2:00 o'clock and proceed with the submission of the Canadian Society of Hospital Pharmacists.



Regina, Saskatchewan,
Wednesday, January, 24, 1962.

-----ON RESUMING AT 2:00 P.M.

SUBMISSION OF THE CANADIAN SOCIETY OF
HOSPITAL PHARMACISTS, SASKATCHEWAN BRANCH

APPEARANCES:

Mr. R. E. McDermit	- Immediate Past-President
Mr. O. Buchko	- Chairman of the Pharmacy Practice Committee
Mr. J. L. Summers	- Associate Professor of Pharmacy, University of Saskatchewan. Director of Pharmaceutical Services of the University Hospital.

---EXHIBIT No. 89: Submission of the Canadian Society of Hospital Pharmacists, Saskatchewan Branch.

--- EXHIBIT No. 89A: Bylaws of the Saskatchewan Branch of the Canadian Society of Hospital Pharmacists.

---EXHIBIT No. 89B: Bulletin of the Canadian Conference of Pharmaceutical Faculties (Volume XIII, August-September)

MR. SUMMERS: Mr. Chairman, Members of
the Commission, we are delighted with this opportunity to



ANGUS, STONFORD & CO. LTD.
TORONTO, ONTARIO

SUMMERS

4433

Regina, Saskatchewan.
Wednesday, January 24, 1902.

SUBMISSION OF THE CANADIAN SOCIETY OF

PHARMACEUTISTS

TO THE

Mr. O. Buckle - Chairman of the
Committee

Mr. J. L. Smeets - Associate Professor
of Pharmacy,
University of
Saskatchewan
Hospital.

---EXHIBIT No. 89: Submission of the
Canadian Society of Hospital
Pharmacists, Saskatchewan Branch.

---EXHIBIT No. 89A: Bylaws of the Saskatchewan Branch
of the Canadian Society of
Hospital Pharmacists.

---EXHIBIT No. 89B: Bulletin of the Canadian
Conference of Pharmacists,
Saskatchewan (Volume XII, August-
September, 1901).

MR. SUMMERS: Mr. Chairman, Members of

the Commission, we are delighted with this opportunity to



1 appear before you today. I am J. L. Summers, Associate
2 Professor of Pharmacy of the University of Saskatchewan,
3 and Director of Pharmaceutical Services of the University
4 Hospital. With me is Mr. O. Buchko, my Assistant-
5 Director at the University Hospital, and also Chairman
6 of our Pharmacy Practice Committee; also Mr. Robert
7 McDermit, Director of Pharmacy at Gray Nuns Hospital,
8 Regina, and Immediate Past-President of the Saskatchewan
9 Branch of the Canadian Society of Hospital Pharmacists.

10 This submission is respectfully presented
11 by the Saskatchewan Branch of the Canadian Society of
12 Hospital Pharmacists; a voluntary organization of
13 pharmacists who practice in Saskatchewan hospitals.
14 Hospital pharmacists are directly associated with two
15 major health services; pharmacy and hospitals. There-
16 fore, the Saskatchewan Branch views with intense interest
17 the proceedings of the Commission and feels a responsi-
18 bility to present such information, opinions, and
19 recommendations as may fall within the sphere of com-
20 petence of the Branch.

21 The Canadian Society of Hospital Pharmacists
22 will be presenting a national brief to this Commission
23 at a later date. This Branch will assist with its
24 preparation. Therefore, this presentation has been
25 limited to hospital pharmacy as it applies to this
26 Province.

27 2. Drug therapy has become an increasingly
28 important part of total patient care in recent years.
29 As a result, the provision of drugs and pharmaceutical
30 services is now considered an essential basic service



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Professor of Pharmacy of the University of Saskatchewan,
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of our Pharmacy Practice Committee; also Mr. Robert
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2. Drug therapy has become an increasingly
important part of total patient care in recent years.
As a result, the provision of drugs and pharmaceutical
services is now considered an essential basic service



1 in the modern hospital. The provision of this service
2 is the function of the hospital pharmacist and requires
3 the assumption of a high order of professional responsi-
4 bility and the full utilization of his time (Reference
5 paragraph 12-16, and Appendix B and C)

6 3. The supervision of dispensing and other
7 pharmaceutical services by a licensed pharmacist is
8 essential for the provision of adequate patient care.
9 However, it is recognized that the full time employment
10 of a pharmacist is impractical for many small hospitals.
11 It is the opinion of the Saskatchewan Branch that all
12 hospitals of a rated capacity of 75 beds or more require
13 the full-time services of a pharmacist. It is therefore
14 recommended that hospitals of 75 beds or more shall em-
15 ploy the full-time services of a licensed pharmacist
16 and shall appoint an additional pharmacist for each
17 additional 100 beds or major portion thereof. It is
18 further recommended that the continued payment of
19 federal grants for hospital operations be contingent
20 upon the maintenance of the above standards of pharmacy
21 supervision. (Reference paragraph 17-23, Appendix B
22 and C)

23 4. The Saskatchewan Branch deplores the
24 deficiency of adequate pharmacy supervision which appears
25 to exist in some government institutions and further
26 recommends that all federal and provincial hospitals be
27 required to meet the pharmacy staffing pattern re-
28 commended above. (Reference paragraph 19-22)

29 5. A Regional Pharmacy Consulting Service is
30 suggested as a means of providing some measure of pharmacy



in the modern hospital. The provision of this service in the function of the hospital pharmacist and requires the assumption of a high order of professional responsibility and the full utilization of his time (Reference paragraph 12-13, and Appendix 8 and 9)

3. The supervision of dispensing and other pharmaceutical services by a licensed pharmacist is essential for the provision of adequate patient care. However, it is recognized that the full time employment of a pharmacist is impractical for many small hospitals. It is the opinion of the Saskatchewan Branch that all hospitals of a rated capacity of 75 beds or more require the full-time services of a pharmacist. It is therefore recommended that hospitals of 75 beds or more shall employ the full-time services of a licensed pharmacist and shall appoint an additional pharmacist for each additional 100 beds or major portion thereof. It is recommended that hospitals of 75 beds or more shall employ the full-time services of a licensed pharmacist upon the maintenance of the above standards of pharmacy supervision. (Reference paragraph 17-22, Appendix 10 and 11)

4. The Saskatchewan Branch deprecates the deficiency of adequate pharmacy supervision which appears to exist in some government institutions and further recommends that all federal and provincial hospitals be required to meet the pharmacy staffing pattern recommended above. (Reference paragraph 19-23)

5. A Regional Pharmacy Consulting Service is suggested as a means of providing some measure of pharmacy



1 assistance to smaller hospitals. It is recommended
2 that a province wide Regional Pharmacy Consulting
3 Service be established in Saskatchewan on an experimental
4 basis and that a federal grant be provided for the
5 conduct of this research program. Detailed requirements
6 will be submitted in a supplementary presentation at a
7 later date. (Reference paragraph 24-27).

8 Mr. Chairman, I might add that the
9 basis for this program is now in operation. There are
10 three such consulting services covering approximately
11 50 small hospitals with a total of 1,000 beds.

12 6. It is respectfully submitted that a shortage
13 of pharmacists in hospitals now exists and is a serious
14 and general deficiency in Canadian health services.
15 One of the major reasons for this deficiency is the low
16 salary scale for pharmacists in most hospitals. This
17 situation is largely due to the failure of hospital
18 management authorities and of government agencies re-
19 sponsible for allocating operating funds to hospitals,
20 to recognize that competition for the professional
21 services of the pharmacist is with the retail, industrial,
22 and academic fields of pharmacy rather than with other
23 hospitals. It is therefore recommended that the basic
24 principles outlined in Appendix C be brought to the
25 attention of the appropriate hospital and government
26 authorities by this Commission. (Reference paragraph 28-
27 31, and Appendix C)

28 Mr. Chairman, we would be most disturbed
29 if the above recommendation were interpreted as a
30 request that the Commission become a salary negotiating



assistance to smaller hospitals. It is recommended

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basis and that a Federal grant be provided for the

conduct of this research program. Detailed requirements

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of pharmacists in hospitals now exists and is a serious

and general deficiency in Canadian health services.

One of the major reasons for this deficiency is the low

salary scale for pharmacists in most hospitals. This

situation is largely due to the nature of hospital

management authorities and of government agencies re-

to recognize fast competition for the professional

services of the pharmacist is with the retail, industrial,

and academic fields of pharmacy rather than with other

hospitals. It is therefore recommended that the basic

principles outlined in Appendix C be brought to the

attention of the appropriate hospital and government

authorities by this Commission. (Reference paragraph 28-

81, and Appendix C)

Mr. Chairman, we would be most grateful

if the above recommendation were interpreted as a

request that the Commission become a salary negotiating



1 instrument for hospital pharmacists. This is most
2 certainly not the intent. It is fully recognized
3 this is a problem which must be worked out between our-
4 selves and the hospitals, but we do feel that unless
5 the highly competent young pharmacists are attracted
6 and retained in hospital pharmacies, hospitals will
7 not get these young people which they require, and,
8 indeed, which they deserve. We feel it is within
9 the bounds of propriety for the Commission to emphasize
10 these principles if they feel that they are sound
11 principles. In fairness to most Saskatchewan hospital
12 administrators, to the Saskatchewan Hospital Association,
13 and also to the Rate Board of the Saskatchewan Hospital
14 services plan, it must be stated that a large measure
15 of agreement in principle to the above has been achieved.
16 The situation has improved significantly over the past
17 few years in spite of extreme budgetary restrictions.
18 It is anticipated that continued efforts on the part
19 of all concerned will bring about increasing favourable
20 results over the next few years.

21 7. Most Canadian hospitals are deficient
22 in space, equipment, and library facilities for the
23 provision of pharmaceutical services. It is recommended
24 that federal hospital construction and operating grants
25 be contingent upon the provision of pharmacy facilities
26 which meet the Canadian Standards for Pharmacy Practice
27 in Hospitals. (Reference paragraph 32 and Appendix B).

28 8. There is an increasing demand for training
29 beyond the undergraduate level for hospital pharmacists.
30 Such training can only be provided by teaching hospitals



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and retained in hospital pharmacies, hospitals will
not get these young people which they require, and,
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administrators, to the Saskatchewan Hospital Association,

and also to the Rate Board of the Saskatchewan Hospital

services plan, it must be stated that a large measure

of agreement in principle to the above has been achieved.

The situation has thereby significantly improved over the past

few years to a state of extreme emergency requirements.

It is anticipated that continued efforts on the part

of all concerned will bring about increasing favourable

conditions over the next few years.

7. That Canadian hospitals are entitled

to space, equipment, and library facilities for the

provision of pharmaceutical services. It is recommended

be contingent upon the provision of library facilities

which meet the Canadian Standards for Pharmacy Practice

in Hospitals. (Reference paragraphs 32 and Appendix D).

8. There is an increasing demand for training

beyond the undergraduate level for hospital pharmacists.

Such training can only be provided by technological



1 affiliated with these universities which include a
2 Faculty of Pharmacy. It is recommended that grants be
3 provided to the Faculties of Pharmacy providing post-
4 graduate training in hospital pharmacy on the basis of
5 \$5,000.00 annually and to the affiliated hospitals on
6 the basis of \$2,000.00 annually for each student enrolled
7 in the program. These funds should be provided through
8 federal-provincial health grants on the basis of 2/3
9 federal and 1/3 provincial. (Reference paragraph 33-
10 36 and Exhibit B).

11 Mr. Chairman, the reason for this portion
12 is that our experience in the training plan which we
13 have operated to date is that a substantial number of
14 the people we train move out into other parts of
15 Canada, and it would be our intent to provide a corps
16 of well trained people that would be sufficiently mobile
17 to move throughout Canada. For this reason we feel
18 that there is a significant federal responsibility here.

19 9. Data based on the experience in public
20 general hospitals in Saskatchewan support the conclusion
21 that there has NOT been a marked increase in the cost
22 of drugs to hospitals over the past few years and further
23 that the cost of drugs has NOT been responsible for
24 any significant increase in total hospital operating
25 costs in this province. (Reference paragraph 37-42)

26 While speaking of hospital drug costs
27 it is respectfully submitted that drug prices and drug
28 costs are not synonymous. We are faced with a paradoxical
29 situation of falling drug prices and maintenance of
30 the drug cost level at, in some cases, a slight increase.



1 Many complex factors such as the length of stay, the
2 degree of drug utilization, the nature of treatment
3 and the type of patient treated have a significant
4 effect on drug costs.

5 10. The Saskatchewan Hospital Services Plan
6 does not cover the cost of all drugs supplied to hospital
7 patients. This deficiency in coverage has resulted in
8 a heavy financial burden occasionally falling upon
9 seriously ill patients. It is recommended that this
10 deficiency be removed and that the payment of federal
11 grants for hospital operating costs be contingent upon
12 the provision of full drug benefits. (Reference
13 paragraph 37, 38, and 39 and Appendix E).

14 11. It is recommended that all hospitals be
15 required to appoint a Pharmacy and Therapeutics Committee,
16 as a committee of their Medical Staff. This committee
17 is the basis of the formulary system and ensures a
18 measure of control of drug utilization without re-
19 stricting the right of the physician to prescribe such
20 medication as he considers necessary for the welfare
21 of his patients. (Reference paragraph 43 and 44 and
22 Appendix B, Section 4.7)

23 Mr. Chairman, many deserving recommendations
24 have already been put before this Commission, most of
25 which require the expenditure of varying sums of money.
26 The Saskatchewan Branch fully recognizes that the
27 public purse is not a bottomless receptacle, and that
28 rigorous priorities must be established for those funds
29 available for health services. As to general priorities
30 we do not feel it is within our competence to spell out

and the type of patient treated have a significant

10. The Saskatchewan Hospital Services Plan

does not cover the cost of all drugs supplied to hospital

patients. This deficiency in coverage has resulted in

a heavy financial burden occasionally falling upon

seriously ill patients. It is recommended that this

deficiency be removed and that the payment of certain

grants for hospital operating costs be continued when

the provision of full drug services. (Reference

paragraphs 2, 3, 4, and 5 of Appendix 1)

11. It is recommended that all hospitals

be required to appoint a hospital administrator and be

an a committee of health, medical, dental, and nursing

and the basis of the hospital's operation and services

measures of control of any of these services will be

striking the right of the physician to prescribe and

of his patients. (Reference paragraphs 4, 5 and 6 of

have already been the basis of this Commission's work of

which require the expenditure of varying sums of money,

The Saskatchewan Health Bill recognizes that the

public purse is not a bottomless receptacle, and that

rigorous priorities must be established for those funds

available for health services. As no general priorities

we do not feel it is within our competence to establish



1 these in any detail.

2 12 It is the considered opinion of the
3 Saskatchewan Branch that the provision of high standards
4 of hospital care is fundamental to a modern health
5 service and should be given first priority. It is
6 further submitted that the introduction of other health
7 services should NOT be at the expense of the standards
8 of hospital care.

9 Within the specific field of hospital
10 pharmacies, we would suggest the following priorities:

- 11 (a) Competent people: We feel this are the first
12 essential.
13 (b) Adequate training for competent people: May we
14 just say this, sir, that if you waste good training
15 on mediocre people all you have is still mediocre
16 people with more training. This is not sufficient.
17 (c) Facilities:

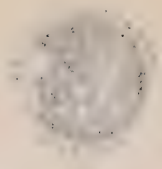
18 Sir, this ends the formal portion of
19 our presentation and we would be pleased to answer
20 such questions as you or members of the Commission will
21 wish to submit.

22 THE CHAIRMAN: Do either one of your
23 associates wish to add anything at this time?

24 I was interested in your reference to
25 priorities, which was an interpolation in your written
26 brief, and you say you give first priority to a high
27 standard of hospital care.

28 MR. SUMMERS: Yes.

29 THE CHAIRMAN: Do you differentiate
30 between hospitals in this regard as to general hospitals



12 It is the considered opinion of the

of hospital care is fundamental to a modern health service and should be given first priority. It is

further submitted that the introduction of other health services should NOT be at the expense of the standards of hospital care.

Within the special field of hospital administration, we would suggest the following priorities: (a) Hospital people: We feel this is the first

(b) Adequate training for hospital people: We feel that say this, etc., that if you waste your training on mediocre people all you have is a staff mediocre people with more training. This is not sufficient.

It is suggested that the formal portion of our presentation and we would be pleased to answer such questions as you or members of the Committee will wish to submit.

THE CHAIRMAN: I thank you very much.

associated with the end of this career.

I am interested in your reference to

priority, which was an interpolation in your written paper and you say that priority is a high standard of hospital care.

THE CHAIRMAN: In your presentation

between hospitals in this regard as to general hospital



1 or mental hospitals?

2 MR. SUMMERS: No, sir.

3 THE CHAIRMAN: All hospitals?

4 MR. SUMMERS: All hospitals, sir.

5 COMMISSIONER STRACHAN: Mr. Chairman,

6 I was wondering if hospital pharmacies are a consideration
7 of the Accreditation Committee of hospitals?

8 MR. SUMMERS: Not as such. The
9 Accreditation Commission states that there shall be a
10 hospital pharmacy or drug room under -- and I think the
11 term is "satisfactory supervision", or some such
12 nebulous term which is open to interpretation. They do
13 not require a licensed pharmacist nor a pharmacy as
14 such.

15 COMMISSIONER STRACHAN: Has your
16 Association or the National Association of Pharmacists
17 made any effort to have such a requirement?

18 MR. SUMMERS: Yes, sir.

19 COMMISSIONER STRACHAN: Without success?

20 MR. SUMMERS: We are in the process.
21 You realize it takes a great deal of time sometimes
22 to institute these recommendations, and we are in the
23 process and we do hope we will meet with a large
24 measure of success. It is our anticipation that we
25 shall.

26 COMMISSIONER STRACHAN: You made some
27 reference in the body of your submission to nurses
28 and their handling of drugs; Do nurses in general have
29 instruction from qualified pharmacists?

30 MR. SUMMERS: Where a pharmacist is on



All hospitals, sir

I was wondering if hospital pharmacists are a consideration of the Accreditation Committee of hospitals?

MR. SUMMERS: Not as such, the

Accreditation Commission states that there shall be a hospital pharmacy on drug room order -- and I think the term is "pharmacy supervision", or some such. It is a term which is open to interpretation. They do not require a licensed pharmacist for a pharmacy as such.

COMMISSIONER STEVENSON: Yes, your

association or the National Association of Hospital Pharmacists. There is no effort to have such a requirement. MR. SUMMERS: Yes, sir.

MR. STEVENSON: We are in the process.

It really takes a great deal of time sometimes to institute these recommendations, and we are in the process and we do hope we will meet with a large measure of success. It is an education that we

COMMISSIONER STEVENSON: You made some

reference in the body of your submission to nurses and their handling of drugs; do nurses in general have instruction from qualified pharmacists? MR. SUMMERS: Where a pharmacist is on



1 the staff of a hospital which has a school of nursing,
2 in most cases or in a number of cases in Saskatchewan
3 such lectures are given by the pharmacist in pharma-
4 cology.

5 COMMISSIONER STRACHAN: And the handling
6 of drugs?

7 MR. SUMMERS: Might I ask what you mean
8 by the handling of drugs?

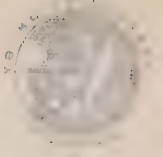
9 COMMISSIONER STRACHAN: Well, I think
10 somewhere you made reference to nurses not being
11 qualified to handle the drugs?

12 MR. SUMMERS: Well, what we have
13 attempted to do is define the division of responsibility
14 between the nurse and the pharmacist. The opposite
A/ 2 15 ends of the scale are quite apparent, but sometimes
16 you are not just too sure where the pharmacist stops
17 and the nurse takes over, and vice versa. We have
18 attempted to define this as being that the function of
19 the nurse is the administration of drugs, and we have
20 spelled out what we mean by administration and what we
21 mean by dispensing.

22 COMMISSIONER STRACHAN: I am referring
23 to page 9, paragraph 26, the last two sentences: "It
24 is respectfully submitted that the education of the
25 nurse does not equip her to exercise such judgment;
26 nor is it intended to do so."

27 MR. SUMMERS: Yes, this is quite true
28 -- if you read it in the proper context.

29 COMMISSIONER STRACHAN: Yes, I admit
30 I didn't do that.



the staff of a hospital which has a school of nursing,
in most cases or in a number of cases in Saskatchewan
such lectures are given by the pharmacist in charge.

COMMISSIONER STANBURN: And the handling

MR. SUMMERS: I am not sure you mean

by the handling of drugs

COMMISSIONER STANBURN: Well, I think

somewhere you made reference to having not being

qualified to handle the drugs

MR. SUMMERS: Well, what we have

attempted to do is define the division of responsibility

between the nurse and the pharmacist. The opposite

ends of the scale are quite apparent, but sometimes

you are not sure where the pharmacist stops

and the nurse takes over. All this means, we have

attempted to define this as being that the function of

the nurse is the administration of drugs, and we have

spelled out what we mean by administration and what we

mean by dispensing.

COMMISSIONER STANBURN: I am referring

to page 9, paragraph 60, the last two sentences: "It

is respectfully submitted that the education of the

nurse does not equip her to exercise such judgment;

nor is it intended to do so."

MR. SUMMERS: Yes, that is quite true

-- if you read it in the proper context.

COMMISSIONER STANBURN: Yes, I admit



1 MR. SUMMERS: In the entire context --
2 and I think most nurses will agree.

3 COMMISSIONER STRACHAN: If you did get
4 the hospital Accreditation Committee to have some
5 qualifications regarding pharmacy, would you hope they
6 would come up to the Canadian standards for the practice
7 of pharmacy in hospitals?

8 MR. SUMMERS: Yes, sir.

9 COMMISSIONER STRACHAN: As outlined in
10 your Appendix B?

11 MR. SUMMERS: Yes, sir.

12 COMMISSIONER STRACHAN: That is your
13 aim?

14 MR. SUMMERS: Yes, that is our aim.

15 COMMISSIONER GIRARD: On Appendix C A-4
16 and A-5, I am not too sure about the difference between
17 Pharmacist III, Director of a pharmacy department in a
18 large hospital, and Director of pharmaceutical services
19 in a large hospital. Are not pharmaceutical services
20 under the pharmacy department? I know you give some
21 explanation here, but I am not too sure. Could you
22 give me more explanation on that?

23 MR. BUCHKO: May I answer that question?

24 COMMISSIONER GIRARD: Yes.

25 MR. BUCHKO: The basic difference,
26 if you are a Director of a pharmacy department, that
27 your responsibilities end there. You are only re-
28 sponsible for pharmacy services itself.

29 COMMISSIONER GIRARD: Only in the
30 pharmacy?



MR. SUMMERS: In the entire context --

and I think most nurses will agree.

COMMISSIONER STANAGAN: If you did get

the hospital Accreditation Committee to have some

qualifications regarding pharmacy, would you agree they

would come up to the Canadian standards for the practice

of pharmacy in hospitals?

MR. SUMMERS: Yes, sir.

COMMISSIONER STANAGAN: As outlined in

Your Appendix B?

MR. SUMMERS: Yes, sir.

COMMISSIONER STANAGAN: That is your

MR. SUMMERS: Yes, that is all, sir.

and A-5. I am not too sure about the difference between

pharmacist III, Director of a pharmacy department in a

large hospital, and Director of pharmaceutical services

in a large hospital. Are not pharmaceutical services

under the pharmacy department? I know you give some

explanation here but I am not too sure. Could you

give me more explanation on that?

MR. BUCHKO: May I answer that question?

MR. BUCHKO: The basic difference,

if you are a Director of a pharmacy department, that

your responsibilities end there. And are only re-



1 MR. BUCHKO: That is right. If you are
2 described as being a Director of pharmaceutical services,
3 this includes everything in the pharmacy plus any other
4 additional services, which may be given to you, and this
5 would include such areas as oxygen-therapy and possibly
6 central supply service and purchasing.

7 COMMISSIONER GIRARD: It would be pharmacy
8 plus?

9 MR. BUCHKO: Plus some other responsibility
10 within the hospital over and above the pharmaceutical
11 department.

12 COMMISSIONER GIRARD: I have another
13 question: It is about central supply service. I know
14 that this is an academic question between pharmacy and
15 nursing, and who should be in charge of central supply,
16 and you say here central supply is under pharmacy. Would
17 you qualify that? Would you say that central supply
18 should be under pharmacy in any case, or would you say
19 in the cases where central supply is doing all the
20 I.V. fluids and sterilization and all that --- would you
21 qualify?

22 MR. SUMMERS: I should say the central
23 supply service may be under pharmacy; that this is a
24 very natural arrangement, (a) where the pharmacist
25 is prepared to assume the responsibility and has the
26 knowledge to so do; and (b) where the nursing service
27 is prepared to give it up. But, again, we are not
28 saying that central supply must necessarily be under the
29 pharmacist. What we are saying is that the old concept
30 of the sterile supply area with student nurses, and in



1 some cases fairly large groups of nurses, were employed,
2 that this no longer obtains; that we feel this is a
3 serious waste of nurses' time, and we have found in our
4 department that we have been able to train lay people
5 to a high degree of technical competence, and in our
6 department where we employ some 35 people we have one
7 nurse who is supervisory and she is the only professional
8 person in the department and she is responsible to me
9 for the supervision of that area.

1 10 COMMISSIONER GIRARD: Could you say
11 also if central supply was under nursing that the
12 same arrangement could be made, there could be one
13 nurse in charge plus some trained people working under
14 this one registered nurse?

15 MR. SUMMERS: The function of central
16 supply is to act as an industrial section of the hospital.
17 It is just like a small factory. We would suggest
18 the pharmacist should not be limited to sterile
19 materials, that any equipment that requires regular
20 maintenance, regular storage and distribution throughout
21 the hospital, can be located in a central issuing area.
22 These responsibilities are more in the nature of a
23 distribution type of operation. We realize that
24 certainly the nurse comes into the picture by specifying
25 the type of equipment she would like delivered to her
26 on this floor, the material for a certain procedure,
27 for instance, a hemorrhage tray or a dressing suture
28 tray, which was specified in consultation with the
29 medical staff, what is to be on that tray. It is
30 up to central supply then to make sure it is available



some cases fairly large groups of nurses, were employed, that this no longer obtains; that we feel this is a serious waste of nurses' time, and we have found in our department that we have been able to train lay people to a high degree of technical competence, and in our department where we employ some 35 people we have one nurse who is supervisory and she is the only professional person in the department and she is responsible to me for the supervision of that area.

also if central supply was better serving that for same arrangement could be made, there would be one nurse in charge plus some of the people working under this one registered nurse.

MR. BOUTWELL: The question of central supply is to set up an industrial section of the hospital. It is just like a small factory. We would suggest the pharmacist should not be limited to sterile materials, that any equipment that requires regular maintenance, regular storage and distribution throughout the hospital, can be located in a central issuing area. These responsibilities are more in the nature of a distribution type of operation. We realize that certainly the nurse comes into the picture by specifying the type of equipment she would like delivered to her on this floor, the material for a certain procedure, for instance, a hemostatic tray or a dressing set, tray, which was specified in consultation with the medical staff, what is to be on that tray. It is to go to central supply then to make sure it is available



1 at the right time and the right place and in the right
2 quantities. We have found that when it comes to the
3 exercise of professional judgment in central supply
4 it is largely in the area of sterilization and we
5 do respectfully suggest that this is within the area
6 of training of a pharmacist, within his area of
7 scientific training.

8 COMMISSIONER GIRARD: When central
9 supply is under pharmacy is it under pharmacy 24 hours
10 a day or under pharmacy during the daytime and under
11 the nurses at night?

12 MR. SUMMERS: It is under pharmacy 24
13 hours a day. I do not mean there is a pharmacist
14 there 24 hours a day, but one is available. When the
15 central supply supervisor is not there one of our
16 senior supervisory people are present in central supply
17 24 hours a day.

18 COMMISSIONER GIRARD: You advocate
19 one licensed pharmacist per 75 beds?

20 MR. SUMMERS: Yes.

21 COMMISSIONER GIRARD: And this is
22 strictly pharmacy and would a pharmacist be fairly
23 busy in a 75 bed hospital? Would he look after ward
24 supplies and things?

25 MR. SUMMERS: Do you mean ward supplies
26 and goods - oh yes, this is part of his function to
27 supply all drugs required in the hospital; he would
28 package, prepare and see that such supplies were
29 delivered to the ward. Our philosophy on service is
30 that everything required by the nurse should be delivered



at the right time and the right place and in the right quantities. We have found that when it comes to the exercise of professional judgment in general supply it is largely in the area of specialization and we do respectfully suggest that this be within the area of training of a pharmacist, within his area of

COMMUNICATIONS CLERK: When a pharmacist

supply is under pharmacy is it under pharmacy 24 hours a day or under pharmacy during the daytime and under the pharmacist's control?

MR. BENTLEY: It is under pharmacy 24

hours a day. I do not mean there is a pharmacist

there 24 hours a day, but one is available when the

pharmacist supply is not there one of our

senior supervisory people are present in our staff supply 24 hours a day.

MR. BENTLEY: You advocate

one licensed pharmacist per 75 beds?

MR. BENTLEY: Yes.

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supply all drugs required in the hospital, he would

package, prepare and see that such supplies were

delivered to the ward. Our philosophy on supplies is

that everything required by the nurse should be delivered



1 to her on the floor and that we should get away from this
2 business, I think we are largely getting away from it,
3 of nurses being messenger boys and running back and
4 forth to the pharmacy. The reason we have that point
5 of view in our brief, the regulations of the Hospital
6 Standards Act in this Province at the present time
7 do require pharmacists for a hospital of 100 beds or
8 more ever since the introduction of schedule G;
9 these are the controlled drug groups under the Food and
10 Drug regulations. This merely increases the work of
11 the pharmacist and, indeed, the whole of the nursing
12 staff.

13 COMMISSIONER GIRARD: But again your
14 pharmacist will be there eight hours and after his eight
15 hours who takes over?

16 MR. SUMMERS: There are a number of
17 things you can do to provide emergency service. In our
18 case there is always a pharmacist on call. There are
19 emergency supplies of drugs at an emergency unit which
20 are packaged and labeled and all that is required is
21 that the nurse leave the order and take the drugs with
22 her.

23 COMMISSIONER GIRARD: Are you talking
24 of the University Hospital now?

25 MR. SUMMERS: Yes.

26 COMMISSIONER GIRARD: I was thinking of
27 a small hospital with 75 beds and only one pharmacist.

28 MR. SUMMERS: In this case we suggest
29 that you set up an emergency type of unit where those
30 drugs normally required in the case of an emergency are



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are packaged and labeled and all that is required in

that the nurse have the order and take the drugs with

her.

COMMISSIONER: Are you talking

of the delivery hospital now?

COMMISSIONER: I was talking of

a small hospital with 75 beds and only one pharmacist.

MR. SUMMERS: In this case we suggest

that you set up an emergency type of unit where there

drugs normally required in the case of an emergency and



1 pre-packaged and where the responsibility for this
2 unit is placed on an individual member of the nursing
3 staff.

4 COMMISSIONER GIRARD: Again we come
5 back to the same thing. Nurses do not want to take
6 over the functions of the pharmacist, this we do not
7 want to do, but it seems to be imposed on us every so
8 often by necessity.

9 MR. SUMMERS: That is quite true and
10 this we must realize and understand. However, what we
11 suggest is that taking a package, a container of medication
12 normally labeled other than the original form or having
13 been labeled by a pharmacist is not dispensing but is,
14 in fact the administration of drugs. We attempt to
15 make this easier for the night staff by arranging
16 those drugs, which will normally be required, in small
17 units conveniently arranged at a central place in the
18 hospital. This has worked most successfully.

19 COMMISSIONER GIRARD: Thank you very much.

20 COMMISSIONER BALTZAN: Professor
21 Summers, on page 1, paragraph 3, I see your very earnest
22 concern about the lack of pharmacists and the advisability
23 of employing pharmacists in hospitals of less than 75
24 beds. My question is: At the areas where there is a
25 pharmacist in a locality, do those areas employ a
26 pharmacist on a part-time basis to help them out?

27 MR. SUMMERS: That is true and we have
28 tried this in a number of our smaller hospitals in this
29 province. This is on an experiential basis. Now,
30 there is one problem here and this is that this is



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COMMISSIONER CHAIRMAN: Again we come

back to the same thing. Nurses do not want to take

over the functions of the pharmacist. This we do not

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in fact the administration of drugs. We suggest to

make this easier for the night staff of hospitals

those drugs, which will normally be required in units

units, conveniently arranged at a central place in the

hospital. This has worked well in hospitals.

COMMISSIONER CHAIRMAN: Thank you very much

Summers, on page 1, paragraph 2, I see your very pertinent

concern about the lack of pharmacists and the availability

of emptying pharmacies to hospitals of less than 15

beds. My question is: At the point where there is a

pharmacist in a locality, do there areas supply a

pharmacist on part-time basis to help them out?

MR. SUMMERS: That is true and we have

tried this in a number of our smaller hospitals in this

province. This is on an experimental basis. Now,

there is one problem here and this is that this is



1 successful only when the pharmacist so employed is
2 genuinely interested in hospital work and is not involved
3 in the hospital as sort of an adjunct to his retail
4 business. In most cases where we have done this
5 successfully we have found in the past month we have a
6 pharmacist doing part-time service in a 75 bed hospital
7 which is requiring most of his time. Therefore, he
8 finds he must either devote himself to his business or
9 to the hospital and this hospital has now requested
10 appointment of a full-time pharmacist.

11 COMMISSIONER BALTZAN: When you say his
12 business you mean confining himself to dispensing of
13 drugs?

14 MR. SUMMERS: In a retail pharmacy, yes.

15 COMMISSIONER BALTZAN: The next page
16 number one, paragraph 5C, how does this regional pharmacy
17 consulting service help or how does it contribute to the
18 deficiency factor in relation to the lack of pharmacists
19 in the area?

20 MR. SUMMERS: Well, of course, the idea here
21 is to assist these hospitals which normally would be too
22 small to employ a full-time pharmacist. We find we
23 could give some measure of assistance to them. To
24 give an example, we are involved in this work and on
25 our last tour in the hospitals of the Humboldt area
26 our major problem was setting up the accounting system
27 for Schedule G drugs and explaining the difference be-
28 tween these drugs and others to the nursing staff.
29 Also we find purchasing problems, nomenclature, providing
30 information on drugs.



successful only when the pharmacist is employed as
 genuinely interested in hospital work and is not involved
 in the hospital as sort of an adjunct to his retail
 business. In most cases where we have done this
 successfully we have found in the past month we have a
 pharmacist doing part-time service in a 15 bed hospital
 which is requiring most of his time. Therefore, he
 finds he must either devote himself to his business or
 to the hospital and this hospital has now required an
 appointment of a full-time pharmacist.
 When you say his
 business you mean something himself to dispensing in
 MR. STONEMAN: In a retail pharmacy, yes.
 number one, paragraph 50, how does this national pharmacy
 consulting service help or how does it contribute to the
 industry rather in relation to the fact of pharmacist
 in the area?
 MR. STONEMAN: Well, of course, the fact that
 is to state these hospitals which normally would be too
 small to employ a full-time pharmacist. We think we
 could give some measure of assistance to them. To
 give an example, we are involved in this work and on
 our part in the hospitals of the hospital area
 our major problem was setting up the accounting system
 for Schedule G drugs and explaining the difference be-
 tween these drugs and others to the nursing staff.
 Also we find purchasing problems, nomenclature, providing
 information on drugs.



1 COMMISSIONER BALTZAN: I was referred
2 to page 8, item 24, and I think thinking in terms of
3 rendering service to the hospital this is more of an
4 advisory council.

5 MR. SUMMERS: Very much so, although
6 in some cases the consulting pharmacist has operated
7 a central purchasing system for some limited number of
8 drugs, he has gone out and done the inventories of the
9 hospital and been a very real service but it certainly
10 is on a limited basis.

11 COMMISSIONER BALTZAN: I think the next
12 question is in the same context. Page 2, paragraph 10,
13 at the bottom of the page, you say:

14 "The Saskatchewan Hospital services plan does not
15 cover the cost of all drugs supplied to hospital
16 patients. This deficiency in coverage has re-
17 sulted in a heavy financial burden occasionally
18 falling upon seriously ill patients."

19 I can very well see that applied in former
20 years, I experienced it a lot, but with the removal
21 of a personal cost, the minimum payment for hospitalization
22 as one leaves a hospital, that would not be nearly as
23 serious as it sounds here?

24 MR. SUMMERS: Well, we have seen patients
25 with drug bills of \$50.00 a day and I would suggest it
26 is reasonably serious.

27 THE CHAIRMAN: Not paid by the plan?

28 MR. SUMMERS: No sir, this was charged
29 to the patient in the group known as chargeable drugs
30 and we submit that although the group known as chargeable



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 referring service to the hospital this is more of an

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 a central purchasing system for some limited number of
 drugs, he has gone out and done the inventories of the
 hospital and been a very real service but it certainly
 is on a limited basis.

COMMISSIONER SALTZMAN: I think the next

question is in the same context. Page 2, paragraph 10.
 at the bottom of the page, you say:

"The State's position is that the plan does not
 cover the cost of all drugs supplied to hospital
 patients. This deficiency in coverage has re-
 sulted in a heavy financial burden occasionally
 falling upon seriously ill patients."

I can very well see that copied in former

years, I experienced it a lot but with the removal

of a personal cost, the minimum payment for hospitalization
 as one leaves a hospital, that would not be nearly as

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with drug bills of \$50.00 a day and I would suggest it

is a very serious.

THE CHAIRMAN: Not said by the plan?

MR. SUMMERS: No sir, this was charged

and we submit that although the group known as chargeable



1 drugs are relatively small, financially spelled out, they
2 do amount to 23% to 25% of the dollar volume of all
3 drugs used in the hospital.

4 COMMISSIONER BALTZAN: It is serious
5 but in the \$50.00 figure it is not just what is ordinarily
6 called drugs, you have in there oxygen and intravenous
7 preparations and other forms of treatment?

8 MR. SUMMERS: No, sir.

9 COMMISSIONER BALTZAN: Just what the
10 patient swallows?

11 MR. SUMMERS: Yes, or injected into him.
12 When we say \$50.00 for drugs this is part of what he had
13 to pay, his total drug bill might be much in excess of
14 that.

15 COMMISSIONER BALTZAN: What things
16 are used on that?

17 MR. SUMMERS: Well, intravenous
18 and hydro-cortisone which comes to some \$3.50 to \$4.00
19 a vial and this is administered every four hours.

20 COMMISSIONER BALTZAN: One hundred
21 milligrams?

22 MR. SUMMERS: Yes, occasionally, and the
23 new drug penbriton, one of the new synethic penicillins
24 coming out, is expensive. I think of a particular case of
25 bacterial-endocarditis where the only effective
26 treatment was an antibiotic called spontim. In this
27 case they were able to save the patient's life but when
28 they were through the patient had a bill for drugs
29 of \$1500.00 and they had almost to re-admit him for
30 shock.



1 COMMISSIONER BALTZAN: That costs a
2 little bit more?

3 THE CHAIRMAN: These exclusions are not
4 uniform throughout Canada, are they?

5 MR. SUMMERS: No sir, this is the only
6 province which has a large number of exclusions. Some
7 of the other provinces have minor exclusions, the only
8 case that comes to mind, and this was a few years ago, it
9 was in British Columbia when they excluded the steroids.
10 However, this to my mind is the only other exclusion
11 that I know of.

12 COMMISSIONER BALTZAN: Page 3, item 2,
13 is that not the case generally in all major hospitals
14 where they have pharmacy committees as part of their
15 medical staff?

16 MR. SUMMERS: Yes, sir.

17 COMMISSIONER BALTZAN: And certainly
18 all teaching hospitals?

19 MR. SUMMERS: Yes. Our point is we
20 have found within the past year, and this is something
21 the consulting pharmacy services have done, they have
22 been able to consult with groups of physicians in the
23 smaller towns and form their small pharmacy committees
24 and establish their useful hospital formularies which
25 have been of great assistance to the hospital and the
26 doctor and have resulted in bulk purchasing in the
27 hospitals.

28 COMMISSIONER BALTZAN: The College of
29 Physicians and Surgeons also has a standing
30 Pharmacy Committee?



1 MR. SUMMERS: Yes.

2 COMMISSIONER BALTZAN: And that is in
3 collaboration with the Department of Public Health in
4 this Province and certainly in regulating some of the
5 drugs that are listed on the free list. Now, you touch
6 on the hospital formulary, in what way is it beneficial
7 from the point of view of costs, reducing costs?

8 MR. SUMMERS: It is beneficial, we feel,
9 through a number of areas: from the direct point of
10 view of the pharmacists. The formulary Committee is based
11 on the fact that the medical staff give a pharmacist
12 authority to exercise his professional judgment in the
13 selection of the trend of drugs which will be stocked
14 in his hospital, where such drug is available from more
15 than one manufacturer, in these hospitals regardless of
16 their names specified. If that given drug is in stock
17 he will use it unless he is specifically instructed to
18 do otherwise. Now, from the point of view of the
19 physician I would suggest that the main object of a
20 formulary is an educational tool - and here we come to
21 this business of generic names. How does the physician
22 know what the generic name is. Any formulary which
23 is effective will list the generic name of the drug
24 plus the comparable brand names which apply to this
25 same drug. It also gives the physician some knowledge
26 of the number of agents with similar therapeutic
27 action which may be available in that hospital so that
28 they may select from these those which he wishes and
29 if they are not there have them brought in.

30 COMMISSIONER BALTZAN: It is more a matter



1 of easy reference, that is what is regarded as a formulary?

2 MR. SUMMERS: Yes, it is. It is not
3 a regulatory book and indeed, it is not an inflexible
4 or what we might call exclusive list of drugs at all.

5 COMMISSIONER BALTZAN: One final question
6 because I wanted to increase my vocabulary. What is
7 the difference between a pharmacist and a druggist?

8 MR. SUMMERS: That is largely a question
9 of semantics.

10 COMMISSIONER BALTZAN: They could be used
11 alternatively?

12 MR. SUMMERS: Synonymously, yes.

13 COMMISSIONER VAN WART: In your summary
14 at page 2, the fourth, you state that there is a
15 deficiency of adequate pharmacy supervision in some
16 government institutions. We turn over to page 7 and
17 we find that there is no supervision in the T.B. Sanitoria
18 or in the Provincial Geriatric hospitals. If you
19 turn to page 14, the T.B. Sanitoria, the drug expense
20 is 4.4 of the hospital expenses yet there is no super-
21 vision by pharmacists in those institutions. How are
22 drugs supervised in those institutions?

23 MR. SUMMERS: I have no idea, I do not
24 know. I might point out that in comparison, the
25 difference is, you must realize, that the scope of the
26 therapy in the general hospital as you well realize
27 better than I do is much broader than that involved in
28 the T.B. Sanitoria, therefore, the selection of drugs
29 and the nature will be much more intense in the general
30 hospital.



1 COMMISSIONER VAN WART: In the modern
2 sanatoria there are large quantities of drugs.

3 MR. SUMMERS: That is true but in the
4 treatment of tuberculosis itself these are relatively
5 limited in variety. I believe they are in large
6 quantities and those are not what we generally consider
7 the expensive drugs.

8 COMMISSIONER VAN WART: Also in the
9 summary, section 5, Dr. Baltzan, asked you about the
10 regional pharmacy consulting services and I would turn
11 over to page 8 to point out that there are 37.4% of the
12 total bed capacity have no pharmacy supervision and
13 you suggest that consulting pharmacy services cover
14 these and you also suggest that it would help these
15 small hospitals in purchasing their drugs from the
16 regional hospital pharmacy at a financial saving. What
17 is the relation of the regional hospital pharmacy to
18 these smaller hospitals?

1 19 MR. SUMMERS: Well, sir, usually
20 these small hospitals voluntarily group themselves into
21 a hospital region, and hire a regional hospital co-
22 ordinator. He then in turn hires a number of consultants,
23 one of whom is often a pharmacist. Now, usually
24 it is better that the consulting pharmacist be a
25 person actually engaged in the practice of pharmacy in
26 a hospital pharmacy, so that his consulting role would
27 be but a portion of his responsibility, in that he
28 would have a home base to work out of, so that he could
29 provide a measure of service in both ---

30 COMMISSIONER VAN WART: You suggest that



1 a test area be established?

2 MR. SUMMERS: Yes sir.

3 COMMISSIONER VAN WART: Would that test
4 area take several of these regional pharmacy units
5 grouped together as a test area, or would you just take
6 one?

7 MR. SUMMERS: No, as a test area, we
8 would like to use the whole Saskatchewan. I would
9 point out that 1,000 of these 2,000 and odd beds that
10 we spoke about a moment ago are now covered by some
11 measure of consulting service, and we would like to
12 see the balance of our hospital beds covered by at
13 least hospital consulting service, and have a degree
14 of purchasing for those few drugs that lend themselves
15 to it.

16 COMMISSIONER VAN WART: And you suggest
17 that this be carried out by Federal funds?

18 MR. SUMMERS: I did, and the reason for
19 it is that this is, to my knowledge, one of the few
20 places in Canada where this regional concept has been
21 developed, and we feel that it has application to many
22 areas in Canada outside Saskatchewan, and that the
23 experience gained by such an experiment might be useful.

24 COMMISSIONER VAN WART: Then, section 6,
25 on the same page of your summary, speaking about a
26 shortage of pharmacists in the hospital, you give as
27 one of the major reasons for this deficiency the low
28 salary scales for pharmacists in most hospitals, and
29 to follow that up, pages 10 and 11, number 30: "The
30 major factor affecting the recruitment of pharmacists in



1 the hospital practice is the low standard of remuneration".
2 Have you any suggestions to make how that should be
3 rectified?

4 MR. SUMMERS: We feel that as we stated
5 the thing is it is not up to this Branch to come up
6 and sort of strike an international salary scale. We
7 think this is not realistic. What we are saying is that
8 within each area the salary scale within the hospital
9 should be comparable to that which is paid to the
10 pharmacist who works in a retail pharmacy, or with a
11 manufacturing concern, because only in this way are we
12 going to retain the best people in hospitals. We
13 really have no difficulty attracting people to hospitals.
14 This type of service appeals to our young students very,
15 very much, and what we find is that we get an able
16 young man into hospitals who is with us one or two
17 years, and then goes into retail pharmacy, or, in our
18 own case, usually into the fields of research and
19 post-graduate training.

20 COMMISSIONER VAN WART: You have a
21 paragraph in Appendix C that industrial pharmacists are
22 well remunerated. Is that from the competition nature
23 of their occupation, the competition among industries,
24 or the industries are just giving more pay?

25 MR. SUMMERS: Yes, and also here is
26 another problem that we have, is that to attract these
27 able young people, you must be able to show them some
28 natural progression that is going to lead them somewhere,
29 and right now we have got to the stage where, all right,
30 so a young man gets to be chief pharmacist in a large



the hospital practice in the low standard of remuneration
Have you any suggestions to make how that should be
rectified?

MR. SUMMERS. We feel that as we stated
the thing is it is not up to this Board to come up
and sort of sit on the international salary scale. We
think this is not realistic. What we are going to do
with each area and salary scale within the hospital
should be comparable to that which is paid in the
community. We would like to have a study, or with a
representative of general, because this is the way we
going to settle the best people in hospitals. We
really have no difficulty with that. We have no difficulty
with the type of salary scale to use, which is very
very good, and what we find is that we get an idea
of what the hospital is doing as well as the
community, and that is really the basis of research and
two cases usually in the field of research and

COMMISSIONER FOR HEALTH: You have a
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well remunerated. Is that from the competition nature
of their occupation, the competition among industries,
or the industries are just paying more pay?
Another problem that we have, is that to attract these
the young people, you must be able to show them some
natural progression that is going to lead them somewhere,
and right now we have got to the stage where, all right,
as a young man goes to be chief pharmacist in a large



1 hospital. Where does he go from there? In industry,
2 there is always the possibility, like a private in the
3 Army rising to be the General, he can some day rise
4 to be President of that company.

5 COMMISSIONER VAN WART: There is
6 competition in industry for his services, which does
7 not exist in hospitals?

8 MR. SUMMERS: That is right sir.

9 COMMISSIONER VAN WART: On page 3,
10 section 8 of your summary, you advocate post-graduate
11 courses in pharmacy, and also you state that the Federal
12 grant should be about two-thirds towards that. Could
13 you enlarge the field of the post-graduate pharmacists,
14 is that a research field, or what field is it in?

15 MR. SUMMERS: No, it would not be a
16 research field, because we feel that within the
17 universities today there are many programs for research.
18 We find that our people going out into hospitals are
19 lacking largely in the administration areas, as well
20 as in additional professional training, and it is on
21 the administration side that we wish to train these
22 people. Training in the hospital community as a
23 whole, training in management and management function,
24 and organization. This is the type of training which
25 our people need.

26 COMMISSIONER VAN WART: Coming to page
27 14, it really is an enlargement of the detail in your
28 summary 3, section 9, you make the statement: "Data
29 based on experience in public general hospitals in
30 Saskatchewan support the conclusion that there has not



1 been a marked increase in the cost of drugs to hospitals
2 over the past few years, and further that the cost of
3 drugs has not been responsible for any significant in-
4 crease in the total hospital operating costs in this
5 Province", and you bring out on page 24 that the "27¢
6 per patient per day in 1959, and 28¢ in 1960, and you
7 also state that in some areas it is only 25¢ per patient
8 per day and then you later, in section 39, in advocating
9 that all drugs be included in an in-patient benefit under
10 the hospital services plan, that the estimated cost would
11 be 40¢ per person per day?

12 MR. SUMMERS: Yes sir.

13 COMMISSIONER VAN WART: Am I to believe
14 that the difference between the twenty-eight and the forty
15 is what you explained to Dr. Baltzan of the drugs that
16 the patient himself is responsible for?

17 MR. SUMMERS: No. Can we turn back to
18 the first part of your question? May I refer you to
19 table 4 on paragraph 38, and here we show the gross
20 patient drug cost. The reason we have used gross is
21 that this includes the cost of all drugs, whether they
22 are paid for by the patient or not. This includes both
23 chargeable and non-chargeable, that is the total cost to
24 the hospital for purchasing drugs. In 1959 it was 80¢
25 per patient per day, excluding oxygen costs. In 1960,
26 it was 91¢ per patient per day, including oxygen costs,
27 and in 1961, to 30th September, that figure was also
28 91¢ per patient per day, and we feel that this is
29 maintaining a normal level of drug costs, that there
30 has been no significant rise. And also, if you check



1 table 5, paragraph 41, we show what this has been from
2 year to year, expressed as a percentage of total hospital
3 operating costs in one hospital only, and this is the
4 reason that we state that we feel that it has not been
5 a significant factor in contributing to a rise in hospital
6 operating costs.

7 COMMISSIONER VAN WART: The figures I
8 quoted were the chargeable drugs?

9 MR. SUMMERS: That is right.

10 COMMISSIONER VAN WART: And you are
11 quoting the over-all non-chargeable, as well as the
12 chargeable?

13 MR. SUMMERS: That is right.

14 COMMISSIONER VAN WART: But the question
15 was in the chargeable drugs, the difference between the
16 28¢ and the 40¢ per day. Is that the item which
17 Dr. Baltzan spoke about?

18 MR. SUMMERS: No sir, we feel that if
19 the drugs which are now chargeable were included as
20 benefits, their cost would rise from 28¢ per patient
21 per day to 40¢.

22 COMMISSIONER VAN WART: In other words,
23 under the plan is a more expensive way of administering
24 drugs than under the present system?

25 MR. SUMMERS: That is right.

26 COMMISSIONER FIRESTONE: Mr. Summers,
27 I take it from your brief that your Society, that is the
28 Saskatchewan Branch of the Canadian Society of Hospital
29 Pharmacists, is in favour of a prepaid drug plan?

30 MR. SUMMERS: Yes sir.



1 COMMISSIONER FIRESTONE: Would you say
2 that such a drug plan should form a part, an integral
3 part of a medical care program?

4 MR. SUMMERS: Yes sir.

5 COMMISSIONER FIRESTONE: Would you say,
6 sir, that a natural extension at some stage or other of
7 the present Saskatchewan Medical Care Plan, would be to
8 include a drug plan to be covered as part of that plan?

9 MR. SUMMERS: Yes sir.

10 COMMISSIONER FIRESTONE: And your
11 Association would support such an extension?

12 MR. SUMMERS: We would sir.

c/ 2 13 COMMISSIONER FIRESTONE: Would you say
14 that in order to introduce a prepaid drug plan, that you
15 would either have the choice of covering all drugs, or
16 to proceed in stages? What would be your preference?

17 MR. SUMMERS: I think this Association
18 supports the Saskatchewan Pharmaceutical Association in
19 their recommendations to the Thompson Committee, that a
20 phased plan be introduced, and we set forth five separate
21 phases. The first of these phases was the inclusion
22 of all drugs which are not now covered in hospitals
23 within such a plan. The second phase was the inclusion
24 of a group of diseased conditions, and we felt that we
25 should specify, or there should be specified diagnoses,
26 plus drugs. That is, we didn't agree that we should
27 begin by covering all drugs for all people. Now, in
28 selecting diagnoses plus drugs this was more or less the
29 thinking that a person who is suffering from rheumatoid
30 arthritis, if that patient is to be on steroid therapy,



1 this becomes very expensive, and does in effect represent
2 a financial barrier to health care. However, if the
3 physician wishes to treat the patient with aspirin in-
4 stead, in his judgment, he can go down to his pharmacist
5 and buy acetylsalicylic acid at about \$1.50 for 500,
6 and by specifying both the diagnosis and those expensive
7 drugs, which may be used for the treatment of this
8 condition, that we would be benefiting, or providing
9 the greatest benefit, to the greatest number of people
10 who really need it.

11 COMMISSIONER FIRESTONE: I take it,
12 Professor Summers, that you have submitted to the
13 Thompson Committee a detailed proposal of those five
14 stages?

15 MR. SUMMERS: We did sir, and this was
16 submitted to you this morning as an Appendix to the
17 Saskatchewan Society of Hospital Pharmacists' brief.

18 COMMISSIONER FIRESTONE: And therefore
19 there is no need to go into the details of it, and we
20 will be able to see it in the records as submitted in
21 your supplementary efforts?

22 MR. SUMMERS: Yes.

23 COMMISSIONER FIRESTONE: It has been
24 suggested to us that certain amendments to the Food and
25 Drug Act would be desirable for a number of reasons.
26 Some reasons include improvement in distribution and
27 prescription. Other reasons suggest that such amendments
28 might contribute to reducing the cost of drugs as sold
29 to the individual at the retail level. Would it be
30 possible for you and your Association to consider specific



1 amendments to the Food and Drug Act, which would serve
2 such objectives, and could such information be submitted
3 to the Commission in writing at a subsequent date,
4 after due consideration by your group?

5 MR. SUMMERS: Yes sir.

6 COMMISSIONER FIRESTONE: Thank you
7 very much, this will be very helpful. My third question,
8 and last question, Professor Summers, concerns the
9 matter of drug prices. Do most hospitals in
10 Saskatchewan use the tender system to purchase drugs?

11 MR. SUMMERS: I would say this, sir,
12 that it is used more frequently than you have been led
13 to believe. This Society certainly agrees in principle
14 with the tender system and I would say that the majority
15 of those hospitals which have a pharmacist on their
16 staff do use the tender system when they feel it is
17 applicable. We might point out several things though,
18 pertaining to the tender system, because we feel that
19 there are certain limitations to it. The employment
20 of tenders presupposes two things: (1) An active
21 pharmacy and therapeutics committee which will give the
22 pharmacist authority to buy one brand of drugs, and
23 dispense that brand for all brands called for on
24 prescription; (2) It is also presupposed that the firms
25 which are requested to submit tenders do sell drugs
26 of equivalent quality. Now, we realize that this matter
27 of quality is a debatable point, sir. On quality I
28 think the best explanation is that given by Dr. Morrell,
29 Head of the Food and Drug Division. This is a quotation
30 from the Toronto Globe and Mail: "When it comes to



1 buying top quality drugs, the things to check are the
2 ability, facilities, personnel, and the conscience
3 of the drug manufacturer, Dr. C.A. Albert Morrell,
4 Canada's Chief Drug Inspector, said today. Neither a
5 brand name nor a drug's generic name is the sole reliable
6 guide to quality, he said. The real point is who
7 makes the drug, and how it is made. The control
8 system that ensures manufacture and scientific testing
9 for potency and stability --- ", and we submit, sir,
10 that in most cases it requires judgment based on training
11 and knowledge to determine this question of equivalent
12 quality, and that the pharmacist is competent to exercise

13 ---

14 COMMISSIONER BALTZAN: Are the potencies
15 of these drugs tested at the Food and Drug Department
16 in Ottawa?

17 MR. SUMMERS: Not necessarily.

18 COMMISSIONER BALTZAN: They are just
19 accepted on face value?

20 MR. SUMMERS: That is right. May we
21 say we would include this in our further written sub-
22 mission. We would point out that in a hospital such
23 as ours there are 4,000 additional drug items in inventory.
24 We deal with some 75 to 100 suppliers, yet we find it
25 practical to submit quotations for under 25 specific
26 drugs for one reason or another.

27 COMMISSIONER FIRESTONE: Professor
28 Summers, I take it that most hospitals call for tenders
29 when large quantities of drugs are involved, and there-
30 fore the bulk of your drug purchases in the larger



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2 ability, facilities, personnel, and the conscience
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14
15 of these drugs tested at one time and used by a man
16 in Canada.
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1 hospitals are based on a tender method?

2 MR. SUMMERS: I would not say a bulk.

3 I would say less than 25 per cent by dollar volume,

4 keeping in mind, for example, intravenous fluids

5 constitute 17% of your total drugs in hospital, and

6 these are not bought on tender; these are bought on

7 contract which is something entirely different again.

8 But, it is approximately, I would say, 25% of your total

9 dollar volume of purchases.

10 COMMISSIONER FIRESTONE: Would you say
11 that the tender system could be extended in the interests
12 of obtaining the least possible price to the hospital?

13 MR. SUMMERS: Not any more than that,
14 because you are faced with a multiplicity of drugs which
15 are used in relatively small quantities rather than
16 large quantities of a large number of drugs. In many
17 cases we require only small quantities, such as 50 or
18 100 tablets, where there is only one supplier. This
19 constitutes approximately 75% of our dollar volume.

20 COMMISSIONER FIRESTONE: We take your
21 word for it, because you are the expert, but are you
22 suggesting that it would be impossible to reduce some of
23 the multiplicity of drugs that are currently on the
24 market?

25 MR. SUMMERS: No, no; what we are suggesting
26 is that this method -- that multiplicity existing
27 covers approximately 25% of dollar volume; that in this
28 other 75% there is no multiplicity by name.

29 COMMISSIONER FIRESTONE: Well, we are
30 not suggesting whether it is multiplicity by name or drugs,



hospitals are based on a tender method?

MR. SUMMERS: I would not say a bid.

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keeping in mind, for example, intravenous fluids

constitute 15% of your total drugs in hospital, and

these are not bought on tender; these are bought on

contract which is something entirely different again.

But, is it approximately, I would say, 25% of your total

dollar volume of purchases.

COMMISSIONER FERGUSON: Would you say

that the tender system could be extended to the interests

of obtaining the best possible price for the hospital?

MR. SUMMERS: Not any more than that.

because you are faced with a multiplicity of drugs which

are used in relatively small quantities rather than

large quantities of a large number of drugs. In many

cases we require only small quantities, such as 50 or

100 tablets, where there is only one supplier. This

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MR. SUMMERS: No, no; what we are suggesting

is that this method - that multiplicity existing

covers approximately 25% of dollar volume; that in this

other 75% there is no multiplicity by name.

not suggesting whether it is multiplicity by name or drugs.



1 but presumably if the drug situation were examined some
2 of the multiplicity that exists now could be reduced;
3 is that correct?

4 MR. SUMMERS: There are means by which
5 it could be reduced. Bulk purchasing is one, and we
6 feel we use this to the fullest extent to which it can
7 be used.

8 COMMISSIONER FIRESTONE: I think you
9 have dealt with the question. May I ask you whether
10 you have at your disposal information on cost variations
11 in response to tenders for drugs of identical quality
12 and type?

13 MR. SUMMERS: Yes, sir.

14 COMMISSIONER FIRESTONE: Can you give
15 us one or two examples between maximum and minimum prices
16 without necessarily naming either the manufacturer or
17 a specific drug, but naming, say, the drug category?
18 We don't want confidential information.

19 MR. SUMMERS: Yes, but I think we must
20 keep in mind that although there may be not much
21 variation in these prices, there is a substantial
22 variation between these and cost prices. Here is an
23 example: 5,000 tablets of a certain drug; the highest
24 quotation was \$19.00 for 500; the least quotation was
25 \$4.29 per 500.

26 COMMISSIONER FIRESTONE: A difference
27 of about 300%?

28 MR. SUMMERS: That is right. Another
29 drug, for one thousand, the highest quotation was \$46.64
30 per thousand; the least quotation, \$22.52 per thousand.



of the multiplying that exists now could be reduced:

is that correct?

MR. SUMMERS: There are means of which it could be reduced. Bulk purchasing is one, and we feel we are close to the fullest extent to which it can be used.

COMMISSIONER FINESTON: I think you

have dealt with the question. May I ask you whether you have at your disposal information on cost variations in response to tenders for items of identical quality and type?

MR. SUMMERS: Yes, sir.

is not on two separate boards, and within a board a board of directors or a committee of directors.

MR. SUMMERS: Yes, but I think we want

keep in mind that although there may be cost variations in these items, there is a substantial variation between these and cost prices. There is an

variation was \$19.00 for 500; the lowest quotation was \$4.29 per 500.

COMMISSIONER FINESTON: A difference

of about 30%

thing. For one thousand, the highest quotation was \$40.00



1 COMMISSIONER FIRESTONE: Over double.

2 Well, we won't go into any further detail. Would it
3 be possible for you to provide us with this type of
4 information, as I say, without giving away confidential
5 information, by categories and in consultation with the
6 Saskatchewan Division of the Pharmaceutical Association
7 -- comparable figures of prices charged at the retail
8 level for the corresponding drug? Would that be possible
9 as a co-operative effort, and could that information be
10 made available to the Commission in writing?

11 MR. SUMMERS: I am sure it could, and I
12 will be happy to do it.

13 COMMISSIONER BALTZAN: We have not to
14 date heard of the role of the wholesale drug houses:
15 could you briefly outline that in relation to the
16 pharmacist -- his supply of medication?

17 MR. SUMMERS: As far as the hospital
18 is concerned, we use the wholesale to a very large
19 degree because we find it impossible to stock all drugs,
20 and we use the wholesale as sort of an additional stock-
21 room to get small quantities of drugs on very short
22 notice. There are a number of suppliers who supply
23 only through wholesale, and therefore in this area we
24 deal with the wholesale in very large volume.

25 THE CHAIRMAN: Thank you very much,
26 Dr. Summers, and your associates. We will be very
27 pleased to have that additional information in a reasonably
28 short time, but take as much time as you may reasonably
29 have to take to get the information together.

30 MR. SUMMERS: Thank you very much, sir;
we are a very small body and we appreciate your time.



1 THE CHAIRMAN: We will now proceed with
2 the brief of the Co-operative Union of Saskatchewan.

3
4 SUBMISSION OF THE CO-OPERATIVE UNION
5 OF SASKATCHEWAN

6
7 ----Exhibit No. 90: Brief of the Co-operative
8 Union of Saskatchewan

9
10 APPEARANCES:

11 Mr. E. K. Scharf Vice President

12 Mr. W. Hamilton Executive Secretary

13
14 -----
15
16 MR. SCHARF: Mr. Chairman and Members
17 of the Commission, on behalf of the Co-operative Union
18 I want to thank you, Mr. Chairman, and the Commission for
19 allowing us to present this submission for your consideration.

20 The Co-operative Union is a federation
21 of co-operatives in the province, the membership of which
22 includes some 300 local retail co-operatives and the
23 provincial or central co-operatives. The central or
24 provincial co-operatives in membership at this time in-
25 clude Federated Co-operatives Ltd., the Sask. Co-operative
26 Creamery Ltd., the Sask. Forage Crop Growers Co-operative,
27 the Sask. Wheat Pool, the Sask. Honey Producers Co-
28 operative, the Credit Union League of Sask., the Sask.
29 Co-operative Credit Society, the Co-operative Trust Co.,
30 the Co-operative Insurance Companies, the Sask. Co-



1 operative Womens Guild, the Sask. Federation of Production
2 Co-operatives, and Canadian Co-operative Implements Ltd.
3 Our business; Mr. Chairman, I might add,
4 in one year exceeds in dollar volume half a billion
5 dollars.

6 THE CHAIRMAN: That is in all forms of
7 merchandise?

8 MR. SCHARF: That is right, and services.

9 In terms of membership of the individual
10 member organizations, the Co-operative Union represents a
11 large number of the people in the province of Saskatchewan.
12 The Commission will recognize from the types of co-
13 operatives that a large proportion of the membership are
14 rural residents. While our consideration of the adequacy
15 of health services is on behalf of the entire membership,
16 we will refer particularly to the question from the point
17 of view of the farmers, and the residents in small
18 villages and towns.

19 Through the years, the people in Saskatchewan
20 have attempted through various organizational approaches
21 to budget their means to provide themselves with health
22 services. Initially, the Municipal health schemes, and
23 subsequently the development of a medical co-operative
24 in Regina and Saskatoon are examples. The Union, as the
25 co-operative organization responsible for co-operative
26 development and promotion in the province has occasionally
27 considered extension of co-operative health services, but
28 no development has been undertaken. In fact, the co-
29 operative Group Health Association in Regina merged with
30 other medical service groups into one of the local



1 voluntary medical insurance plans. Nonetheless, the
2 Union continues to be vitally interested in programs and
3 policies which might be developed to provide the maximum
4 of opportunity for the greatest numbers to enjoy the
5 highest standards of health.

6 The Union appreciates that the Commission's
7 terms of reference are broad indeed, and that the subject
8 is complex and specialized. The Union approaches the
9 question from the view that health services should be
10 accessible to all who require service. This brief is
11 therefore presented to:

- 12 (a) Outline what we consider to be the broad
13 characteristics of an adequate health service.
- 14 (b) Consider present services against this definition.
- 15 (c) Review the accessibility of services.
- 16 (d) Outline some views on how services can be made
17 more accessible.
- 18 (e) Suggest Federal-provincial responsibilities in
19 provision of health services.
- 20 (f) Draw the Commission's attention to the
21 particular problems of inadequacy of dental
22 services, and the cost of drugs.

23 Characteristics of an Adequate Health Service

24 In the past few years there has been an
25 enlarging demand for health services of one kind or other,
26 and the demand has resulted in expanded developments and
27 services of one kind or other. Science continues to
28 provide new opportunities to prevention, detection and
29 control of disease or illness. But how well our health
30 services are organized to utilize modern science and



1 technology is the question.

2 In our view, the real purpose of a health
3 service program is to provide an optimum of health to as
4 many people as possible.

5 A health service program which would serve
6 this objective should be:

7 (a) Comprehensive.

8 (b) Adequately staffed with well-trained personnel.

9 (c) Co-ordinated and integrated.

10 (d) Accessible to the public regardless of age, state
11 of health, geographic location or personal wealth.

12 (e) Up-to-date and able to take advantage of new
13 developments.

14 Comprehensive Health Services

15 The maintenance of health requires that action
16 be taken on a broad front. Programs of prevention, diagnosis
17 treatment and rehabilitation are required. These
18 different programs must be kept in perspective and
19 they must be co-ordinated. When we speak of preventive
20 medicine, we generally think only of immunization and
21 sanitation programs. But prevention surely includes the
22 atmosphere in which people live - the physical and
23 social environment. Undoubtedly greater attention to
24 for example, housing programs would have an effect on
25 health levels. Recreation (both physical and non-
26 physical) is another facet of maintenance of health, and
27 should not be overlooked in overall programming.

28 The very obvious part of a comprehensive
29 health program is the services of the family physician
30 including diagnostic and treatment services. This area



1 may involve hospitalization and the use of specialist
2 services at all stages from diagnosis, through treatment
3 and convalescence. Another important aspect of com-
4 prehensive health services is the area of rehabilitation
5 including rehabilitative medicine, occupational re-
6 habilitation, convalescent facilities, home care
7 facilities and service.

8 We would anticipate that through each of
9 these areas of health care there may be a role for social
10 workers and the different voluntary health activities.

11 A comprehensive health service then would appear to us to
12 involve the activities of departments of public health
13 and social welfare; medical practitioners and medical
14 colleges; and hospital planning and development programs,
15 as well as some voluntary programs.

16 We are concerned that the "comprehensiveness"
17 of a service of this scope be left to chance. Planning
18 and co-ordination must be undertaken by some authority
19 otherwise there will be no balance between the various
20 aspects of the service.

21 Staff Requirements

22 An outline of a comprehensive program
23 means nothing unless there is sufficient numbers of well-
24 trained personnel to staff the required facilities and
25 programs. Reference will be made in a later section
26 to the location of physicians and the need for increased
27 numbers in the rural areas particularly.

28 In commenting on the adequacy of health
29 services (including staff complement) in Saskatchewan
30 the Union acknowledges that an authoritative review of



may involve hospitalization and the use of specialist

and convenience. Another important aspect of con-

prehensive health services is the area of rehabilitation

including rehabilitative medicine, occupational ther-

apies, convalescent facilities, home care

these areas of health care where there may be a role for social

workers and the different voluntary health activities.

A comprehensive health service program should appear to us to

involve the activities of departments of public health

and social welfare, medical practitioners and hospital

colleges, and hospital planning and development programs,

as well as some voluntary programs.

We are concerned that the "comprehensive

of a service of this type be left to chance. Planning

and co-ordination must be undertaken by some authority

otherwise there will be no relation between the various

aspects of the service.

Staff Participation

An outline of a comprehensive program

means nothing unless there is sufficient numbers of well

trained personnel to staff the required facilities and

programs. Reference will be made in a later section

to the location of facilities and the need for increased

numbers in the rural areas particularly.

In commenting on the adequacy of health

services (including staff complement) in Baltimore

the United States acknowledges that no authoritative basis of



1 all aspects requires research considerably beyond our
2 means. We know that the Commission will find the final
3 report of the Advisory Planning Committee on Medical
4 Care, and the Annual Reports of the Department of Public
5 Health to be most useful in describing the adequacy of
6 health services in the province.

7 However, in our experience there are
8 insufficient services in some rural areas. To meet
9 demands for more service, increased numbers of profes-
10 sional staff will be required, the numbers being somewhat
11 dependent on the resources available to concentrate the
12 programs, and the extent to which our population continues
13 to concentrate in the cities and larger towns.

14 Co-ordination and Integration

15 In an overview of health services we are
16 impressed that there are many legal jurisdictions,
17 agencies, organizations and individuals, each providing
18 facilities and/or services for the general public,
19 different age groups, or special disease groups.

20 Without making judgments of the adequacy
21 to which these various services are provided, the Co-
22 operative Union is concerned with the question of co-
23 ordination and efficiency.

24 We would hope the Commission in the
25 course of its study will be able to assess the economic
26 efficiency with which these various kinds and levels
27 of service are provided when administrative costs are
28 duplicated due to the multiplicity of providers of
29 different services.

30 Probably more important than any duplica-



1 tions of costs is the question of care of patients who
2 need to consult with different groups to get the service
3 they require, or whose care after treatment, is dis -
4 rupted, in transfer of responsibility from one jurisdiction
5 to another. As noted above we foresee the need for much
6 closer co-ordination and integration of all aspects of
7 comprehensive health programming.

8 Accessibility of Health Services to the Public

9 The Co-operative Union accepts that health
10 services must be judged not only in terms of the com-
11 prehensiveness of the health program and the numbers of
12 personnel and facilities for the variety of aspects to
13 good health, but also in terms of the extent to which
14 modern health and medical technology is accessible to all
15 the people who would use such services.

16 We firmly believe that the advances of
17 science and the development of means to improve the health
18 and welfare of the population ought to be available to
19 people regardless of where they happen to be located
20 in the nation, regardless of their personal wealth, age,
21 or state of health.

22 We believe that services must be accessible
23 both in terms of where they are located relative to the
24 people, and in terms of how well the population is able
25 to pay for the services. We would submit that modern
26 health services are inaccessible to many of our people,
27 because of either or both location and cost.

28 The Rural Situation

29 The Co-op Union recognizes that the
30 provision of adequate health services to rural Saskatchewan



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 need to consult with different groups to get the service
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 health services are inaccessible to many of our people,
 because of either or both location and cost.

The Co-op Action recognizes that the

provision of adequate health services to all people



1 creates special problems. The Union has nonetheless
2 been impressed with the continuous and expanded efforts
3 to provide people with improved health services. The
4 Air Ambulance Program, and the expansion of the Regional
5 Health Program with its wide range of preventive services
6 provided by full time, well trained Public Health
7 personnel, are examples of the attempt to provide better
8 opportunity.

9 In spite of these programs the Union
10 wishes to emphasize to the Commission that rural people
11 do not have available to them the same opportunities
12 of either quantity or quality of service as do people
13 in urban centers.

14 Considering physicians services alone,
15 in 1961 50% of the practising physicians were located
16 in the three urban centers of Moose Jaw, Regina and
17 Saskatoon. Approximately 500 of the 755 were located
18 in the eight cities of the province thus leaving about
19 270 to serve all other areas.

20 We appreciate that many rural people use
21 the centrally located services but submit that these
22 same facilities are much less accessible to a large part
23 of the rural population.

24 The Commission will appreciate that for a
25 farmer patient to take advantage of the special services
26 available only in the major centers, there are costs of
27 transportation and possibly the costs of hiring re-
28 placement on the farm. In addition if some considerable
29 time is involved in clinic visits the patient has the
30 extra costs of living in the urban center. All of these



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2 been impressed with the conditions and expanded efforts
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4 Air Ambulance Program, and the expansion of the Regional
5 Health Program with the wide range of preventive services
6 provided by full time, well trained Public Health
7 personnel, and expansion of the attempts to provide better
8 opportunities.
9
10 In spite of these programs the Union
11 wishes to emphasize to the Commission that rural people
12 do not have available to them the same opportunities
13 of either quantity or quality of services as do people
14 in urban centers.
15
16 In 1961 50% of the population in India was located
17 in the three urban centers of Bombay, Madras and
18 Bhubaneswar. Approximately 50% of the 425 were located
19 in the eight cities of the Province and a further about
20 25% in the other urban centers.
21
22 We are aware that rural people use
23 the centrally located services but admit that these
24 same facilities are much less accessible to a large part
25 of the rural population.
26
27 The Commission will appreciate that for a
28 better patient to take advantage of the special services
29 available only in the major centers, there are costs of
30 transportation and possibly the costs of living re-
31 placement on the farm. In addition if some consideration
32 time is involved to obtain visits the patient has the
33 extra costs of living in the urban center. All of these



1 various kinds of costs are actually added costs to the
2 health service.

3 The Co-operative Union appreciates that
4 low and unstable farm income, together with the "pro-
5 fessional isolation" of a small community are factors
6 which deter many qualified physicians from locating and
7 serving in the rural areas.

8 We are hopeful that the Commission will
9 be able to recommend programs through which rural
10 people will be able to gain access to all of the re-
11 sources of a modern medical and health service. We
12 submit that finances should be made available for the de-
13 velopment of regional diagnostic and specialist medical
14 care centers which would attract well qualified specialist
15 physicians to locate outside of the two large urban
16 centers of Saskatchewan. This kind of development along
17 with the use of travelling consultative clinics would
18 appear to hold real possibility for not only serving
19 the rural people more adequately, but would help to
20 maintain physicians in rural communities. It is clear
21 that general practitioners in rural areas require
22 sufficient professional stimulation and assistance as
23 well as financial incentives to work and remain in the
24 small centers.

25 While it could be argued that an informal
26 referral system between rural general practitioners and
27 urban specialists would overcome to some extent, the
28 disparity of service caused by lack of specialist services
29 in the rural areas, we would again emphasize that the
30 rural people would not necessarily be as well served as



1 the urban.

2 Prepayment Plans

3 In recognition of the desirability of
4 prepaying, or hedging against large unplanned-for
5 medical expenses, the Municipal Doctor plans came into
6 being some years ago. Farmers usually pay a land tax
7 and some personal tax. Although these programs have
8 been, and are of real value, there are currently only
9 about 80 rural municipalities, twelve towns, and four
10 villages with plans. Of the 132, 79 offered both
11 medical and surgical services, 53 a basic general medical
12 service.

13 In recent years the costs have risen to
14 the extent that either taxes have had to increase, or
15 municipalities have had to apply deterrent fees, or re-
16 strict the amount of medical fees that could be paid
17 in any given year.

18 Much of the population is covered by
19 medical insurance programs of one kind or other. For
20 many urban people coverage of this kind is a fringe
21 benefit of employment. Certainly the advantages of
22 group contract are usually available to urban residents
23 and not to rural people.

24 According to our information the two
25 large voluntary insurance programs (G.M.S. and M.S.I.)
26 between them have some 70,000 residents of rural
27 municipalities under contract which represents less than
28 25% of their collective coverage.

29 These various plans have been most
30 beneficial to those who could use them. However, it is



1 our view that many people in Saskatchewan are unable to
2 finance premiums for prepayment of health insurance.
3 To the extent that they are not, they are much less able
4 to provide themselves with an adequate health program.
5 Many others have been unable to use the programs for
6 other reasons.

7 Universal and Comprehensive Health Services

8 We believe that comprehensive health
9 service programs should be accessible to the entire
10 population, and we submit that national funds should be
11 used to assist with a program of this kind.

12 We would anticipate that assistance for
13 the development of more good rural hospitals or clinics
14 would make services more accessible to rural people.
15 To the extent that programs of this kind are developed
16 we recognize that additional numbers of professional
17 personnel will be required and therefore training pro-
18 grams will have to be considered in the overall develop-
19 ment of comprehensive health service.

20 Further to the extent that new develop-
21 ments are required in rehabilitative health services we
22 would foresee some changes in organization. For
23 example the extent to which convalescent homes or home
24 care, or more attention to aged indigents become part of
25 the total health program, then to that extent the re-
26 organization of hospital funds and medical resources will
27 become necessary. There is need for maximum co-
28 ordination between the various areas of health service
29 since various developments cannot be considered apart
30 from the whole program.



our view that many people in Saskatchewan are unable to finance premiums for payment of health insurance. To the extent that they are not, they are much less able to provide themselves with an adequate health program. Many others have been unable to use the program for

We believe that comprehensive health service programs should be accessible to the entire population and we believe that national funds should be used to assist with a program of this kind. We would anticipate that assistance for the development of more good rural hospitals or clinics would make services more accessible to rural people. To the extent that programs of this kind are developed we recognize that additional numbers of professional personnel will be required and therefore training programs will have to be considered in the overall development of comprehensive health services.

First of all the extent that new developments are required in rehabilitative health services we would foresee some changes in organization. For example the extent to which convalescent homes or home care, or more attention to aged individuals become part of the total health program, then to that extent the reorganization of hospital funds and medical resources will become necessary. There is need for maximum coordination between the various areas of health service since various developments cannot be considered apart from the whole program.



1 Federal-Provincial Aspects

2 Since we believe that comprehensive health
3 services should be within the reach of every Canadian
4 resident, regardless of income, health condition and
5 geographic location it follows that a national approach
6 is essential.

7 We believe that ideally a comprehensive
8 Canadian health program should be established. Minimum
9 standards of service should be set to apply all across
10 Canada, and national funds should be used to finance
11 such a program.

12 However, since it is constitutionally
13 impossible for establishment of a national health program,
14 we would submit that the Federal Government should pay
15 grants to the provinces on conditions of meeting at
16 least a certain minimum standard of health services,
17 and that such funds should be administered by the
18 provincial governments. We believe that some form of
19 equalization principle should be used to take account of
20 such factors as the costs of providing services in the
21 less densely populated areas.

22 We believe further that each individual
23 should have some measure of direct personal responsibility
24 for the program. Therefore we suggest that each self
25 supporting individual should pay a modest direct premium,
26 or tax toward the upkeep of such a program.

27 The Co-operative Union, interested in the
28 development of voluntary co-operatives, has considered
29 the possibility of developing medical co-operatives
30 through which the consumers might insure themselves, and



Federal-Provincial Agreements

Since we believe that comprehensive health

services should be within the reach of every Canadian

geographic location it follows that a national approach

is essential.

We believe that ideally a comprehensive

standards of service should be set to apply all across

Canada, and national funds should be used to finance

such a program.

However, since it is constitutionally

impossible for either federal or provincial health programs

we would agree that the federal government should pay

grants to the provinces for the purpose of meeting the

basic health needs of their people.

and that such funds should be administered by the

provincial governments. We believe that some form of

education principle should be used to take account of

such factors as the costs of providing services to the

less densely populated areas.

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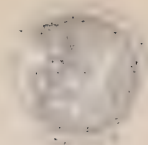
or tax towards the upkeep of such a program.



1 through which subsidies might be paid. We have con-
2 cluded that subsidies to voluntary programs will not
3 achieve the kind of comprehensive programming in which
4 we are interested. We emphasize that our interest is
5 in the provision of comprehensive programming, and
6 voluntary plans, co-operatives included, responsible for
7 only medical insurance, will not achieve the kind of
8 co-ordinated integrated approach which will be necessary
9 for providing a maximum of health service to the popula-
10 tion.

11 Questions of universal application,
12 equitability of cost, the training and efficient use of
13 highly trained personnel and responsibility for the
14 quality of services offered all militate against the
15 development of voluntary programs, albeit with fiscal
16 subsidy, as vehicles for the extension of comprehensive
17 health services.

18 In pursuit of comprehensive health care,
19 accessible to all, we are led to the conclusion that
20 national support for universal and comprehensive programs
21 administered through departments of public health should
22 be ultimate and long-term objectives. This is not to
23 suggest that departments of health would completely
24 administer the health needs of the nation, but rather that
25 co-ordination and development of programs, including
26 means to staff these programs, would come within the
27 purview of the departments of health as the representative
28 authorities for the health and welfare within the
29 province. While outside the province the national
30 government would be responsible.



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tion of the United States.

Education of cost, the training and efficient use of
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subsidy, as vehicles for the expansion of comprehensive
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In pursuit of comprehensive health care,
associated with all, we are led to the conclusion that
national support for universal and comprehensive programs
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be ultimate and long-term objectives. This is not to
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administer the health needs of the nation, but rather that
co-ordination and development of programs, including
plans to staff these programs, would be within the
purview of the department of health as the representative
authorities for the health and welfare within the
provinces. While outside the province the national
government would be responsible.



1 Dental Services

2 We want to draw the Commission's attention
3 to the inadequacy of dental services, particularly in
4 rural Saskatchewan.

5 According to our information there are
6 only about 180 practising dentists in Saskatchewan, over
7 half of whom are practising in the five largest cities.
8 This means that there are only about 70 dentists to serve
9 the rest of the province.

10 This situation causes considerable hard-
11 ship to rural people who have to wait usually for extended
12 periods to get appointments, and then travel considerable
13 distances to get service. Anything which disrupts the
14 keeping of appointments merely aggravates the problem.

15 We are hopeful that the Commission will
16 be able to make some study of the reasons for the
17 shortage of dentists, and we look forward to the re-
18 commendation of programs which will alleviate the
19 problem.

20 Drug Prices

21 The question of drug prices has been
22 periodically raised by co-operative members and co-
23 operatives. While we have not made a study of the matter,
24 we believe that the question requires investigation.
25 We realize that the Restrictive Trade Practices
26 Commission has been working with this matter, and we
27 hope that your Commission will review the situation
28 so that the public can be assured that drug prices are
29 not excessive.

30 In summary, we would recommend that:



1 (a) A universal, comprehensive health services
2 program be established in Canada, with
3 national standards of service being
4 established.

5 (b) Co-ordination, planning and integration
6 of the various aspects of the health
7 service be done through provincial depart-
8 ments of public health.

9 (c) National funds be used to support the
10 program, with self supporting individuals
11 paying a modest direct tax to support
12 of the program.

13 (d) Immediate consideration be given to
14 measures which would assist in alleviating
15 the shortage of dental services in the
16 province.

b 1 17 THE CHAIRMAN: Thank you, Mr. Scharf.

18 As you appreciate - Mr. Hamilton, do you wish to add
19 anything?

20 MR. HAMILTON: No.

21 THE CHAIRMAN: As you appreciate, you
22 have read your brief in full and I would say that it
23 is accepted as a brief which has been prepared with care
24 and thought and expresses what we might call the grass
25 roots viewpoint of the problems of self services
26 particularly with reference to rural areas. We
27 appreciate having your views put forward so forth -
28 rightly and with such clarity. Of course, when the
29 brief has been read in its entirety it does obviate
30 the necessity of questioning you in detail in many of the



1 aspects we would have had to develop if the brief had
2 not been read completely. However, some of the
3 Commissioners may have some questions. Dr. Strachan?

4 COMMISSIONER STRACHAN: I think I
5 agree with the Chairman, this Co-operative Union have
6 made their case quite clear and I do not think any
7 question on my part would add anything further to their
8 presentation.

9 THE CHAIRMAN: Perhaps there is one
10 question which is of a very general nature. While
11 you spell out in full your views on the kind of
12 program you would like to see inaugurated, I would
13 like to put the question to you directly, is the program
14 which you advocate here compulsory?

15 MR. SCHARF: We advocate the setting
16 up of a program in order to qualify for the full
17 subsidies within each province, each province would
18 be set up and would depend, of course, on the provincial
19 authorities within the province. We think definitely
20 that the funds come from the Federal Government, the
21 Provincial and from the individual.

22 THE CHAIRMAN: From the users who are
23 able to pay?

24 MR. SCHARF: Yes, but there would be
25 minimum regulations in order to qualify for subsidy.

26 THE CHAIRMAN: And you would leave it
27 to the individual provinces to work out their own
28 program?

29 MR. SCHARF: We would have to.

30 THE CHAIRMAN: That is recognizing



not been read completely. However, some of the

Commissioners may have some questions. Dr. Stuchlik?

Thank you.

made their case quite clear and I do not think any

question on my part would add anything further to their

presentation.

THE CHAIRMAN: Perhaps there is one

question which is of a very general nature. While

you speak out in this way as you did of

today. You would like to see the law. I would

like to put the question to you directly. Is the program

which you advocate here compulsory?

MR. STUCHLIK: We should have the option

of a program in order to get the best results

and the within each province and province would

be set up and would report on the results

and report within the province. The law would be

that the funds come from the federal government. The

provincial and local individuals.

THE CHAIRMAN: From the report was one

able to pay?

MR. STUCHLIK: Yes, but there would be

THE CHAIRMAN: And you would leave it

to the individual provinces to work out their own

program?

MR. STUCHLIK: We would have to

THE CHAIRMAN: That is recognizing

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1 reality. Do you foresee that this could be done on an
2 individual provincial basis, that is one province at
3 a time, or that it would have to come into being with
4 a certain number of provinces when they were willing
5 to meet this minimum basis you have mentioned or certain
6 proportion of the total population?

7 MR. SCHARF: Our brief is based on a
8 national scheme of this particular kind and we would
9 hope it would not be too long before a number of the
10 provinces would adopt a scheme which would at least
11 reach the minimum services set. We would not be in
12 a position to say how many provinces, but there is a
13 trend towards activity on behalf of the provincial
14 departments of health with respect to their program and
15 we hope it will be the kind of comprehensive program
16 that will enable people to get the service they need.

17 MR. HAMILTON: It could happen without
18 all of them being in.

19 THE CHAIRMAN: But you are not realistic
20 enough to appreciate that it would be too much to expect
21 it would be done for one province only?

22 MR. SCHARF: I think so because the
23 Dominion Government would scarcely be justified in
24 giving a subsidy to only one. That would be my personal
25 opinion.

26 COMMISSIONER FIRESTONE: Just one
27 question. On page 12 the proposal is made that the
28 Commission will review the situation so that the public
29 can be ensured that drug prices are not excessive.
30 Have you any specific areas in mind which the Commission



3 a time, or that it would have to come into being with
4 a certain number of provinces when they were willing
5 to meet this minimum figure you have mentioned or certain
6 proportion of the total population.

7 MR. CHAIRMAN: Your brief is based on a
8 national scheme of this particular kind and we would
9 hope it would not be too long before a number of the
10 provinces would come to an agreement to join at least
11 nearly the whole country. It would be in
12 a position to say how many provinces, but there is a
13 front line of provinces which are not provincial
14 departments. It might be possible to have a number of
15 we hope it will be the kind of a federation of regions
16 that will enable people to get the work of a great world.

17 MR. CHAIRMAN: It is a question without
18 all of them being in.
19 MR. CHAIRMAN: But you are not satisfied
20 enough to agree that it is not too much to expect
21 it would be done for the time being.

22 MR. CHAIRMAN: I think so because the
23 Dominion Government would naturally be justified in
24 giving a subsidy to such a group. They would be as personal
25 opinion.

26 JOURNALIST: FIRST QUESTION. Just one
27 question. On page 12 the proposal is made that the
28 Government will consider the matter as far as the public
29 can be satisfied that their interest are not excessive.
30 Have you any specific ideas in mind with the Commission



1 could study? Would you for instance feel we ought to
2 look into the question of why costs are high and what
3 are some of the reasons for what you call excessive
4 prices, whether it is due to the fact that some drugs are
5 controlled and many others are not. Is that what you
6 mean?

7 MR. SCHARF: Yes, and after listening
8 to the Pharmacists Association's brief we know you will
9 be in a position to give some leadership in respect to
10 various aspects of the drug business which affect the
11 ultimate price of the consumer. Also we would be
12 interested in some ways or means of enabling the consumer
13 to use good judgment in the purchasing of such drugs
14 as he does purchase outside the prescription area.

15 MR. HAMILTON: I was going to observe
16 that our organization being a member of the Federation of
17 Agriculture and it of the Canadian one we were involved
18 in considering whether we ought to look into this
19 question with the Restrictive Trade Practices Commission
20 when they were having their hearings here. We have
21 available to us the report of the Director of Research
22 but we have not been able to make a study to determine
23 how much of his report we really can stand behind. I
24 am sure that is available to you people.

25 THE CHAIRMAN: I understand. My information
26 is that the Canadian Federation of Agriculture will be
27 making a statement to the Commission in Ottawa.

28 MR. HAMILTON: That is right.

29 COMMISSIONER FIRESTONE: And presumably
30 they will be dealing with the question of drug prices?



1 MR. HAMILTON: I presume so
2 because I have literature prepared by the Secretary.

3 COMMISSIONER FIRESTONE: I take it there
4 will be no harm in you passing on the interest of the
5 Commission, the questions that have been asked of you
6 to the Canadian Federation of Agriculture if you wish
7 to submit that in Ottawa.

8 MR. HAMILTON: We could have elaborated
9 but we did not.

10 THE CHAIRMAN: Thank you for this very
11 clear, concise and as I say, 'grass roots' brief. You
12 may be sure it will have our consideration.

13 MR. SCHARF: Thank you, Mr. Chairman and
14 Members of the Commission for your very courteous hearing
15 of our brief.

16 THE CHAIRMAN: The next brief will be the
17 submission from the Saskatchewan Anti-Tuberculosis
18 League.

19 THE SECRETARY: That will be Exhibit
20 number 91.

21

22 ---EXHIBIT No. 91: Submission of Saskatchewan Anti-
Tuberculosis League.

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SUBMISSION OF THE SASKATCHEWAN ANTI-
TUBERCULOSIS LEAGUE

APPEARANCES:

Dr. G. D. Barnett

Mr. F. Froh

DR. BARNETT: In presenting this brief

I will just read for you the Summary I have made.

1. The Saskatchewan Anti-Tuberculosis League, incorporated by Provincial Legislation in 1911, has the sole responsibility for the care, control and prevention of tuberculosis in Saskatchewan.

2. Since 1924 the Provincial Government has been responsible for providing the necessary buildings and equipment operated by the League.

3. In 1929 the cost of treatment of tuberculosis was removed from the individual patient. A tax-supported program was established by Provincial legislature.

4. Up to 1961 the League operated sanatoria at Fort Qu'Appelle, Saskatoon and Prince Albert. The three institutions, at one time, had a combined capacity of 803 beds. Since 1955 the number of beds have been gradually reduced because of the decreasing number of patients requiring treatment. This trend was climaxed in 1961 when the Prince Albert institution was returned to the Provincial Government to be used for the treatment of mental defective patients.

5. It is expected that the demand for active treatment beds will continue to decline in the years ahead.



1 The present institutions at Fort Qu'Appelle and Saskatoon
2 will shortly be too large in respect to the problem with
3 which they have to deal.

4 THE CHAIRMAN: As a matter of fact I
5 think there was some news in the paper?

6 DR. BARNETT: That is right.

7 6. The closing of an institution deprives the
8 preventive services of valuable personnel and equipment
9 which previously was shared by the treatment service and
10 the preventive service.

11 7. The preventive service must be continued
12 and even expanded in the future if our present progress
13 is to be continued. The results from our mass tuber-
14 culin surveys show that approximately 20% of the popu-
15 lation has a positive tuberculin test, which indicates
16 that they have been exposed to the T.B. germ and, in fact,
17 harbor it some place in their body. The other 80% of
18 the population have never been exposed to this infection
19 and can, therefore, be considered more susceptible to the
20 spread of infection if an open case of tuberculosis is
21 left undetected in the community. It is, therefore,
22 imperative that the preventive services continue to
23 search for the undetected new cases of active disease in
24 the community.

25 8. Table IX in the appendix shows that the
26 urban centres have become the major source of new active
27 cases of tuberculosis. Case rates are higher in the
28 urban centres than they are in the rural areas. There-
29 fore, preventive services should be located in the large
30 centres and readily accessible to the smaller urban centres.



1 9. Preventive services have been financed
2 by public subscription through the sale of Christmas
3 Seals, Endowment Fund interest, Associated Canadian
4 Travellers contributions, and Federal Government National
5 Health Grant. The National Health Grant has been de-
6 creasing each year as the sum that is available to each
7 province is determined by a formula which utilizes the
8 tuberculosis death rate. This rate is no longer an
9 adequate index of tuberculosis control since the use
10 of modern anti-tuberculosis drugs in present day treat-
11 ment are effective in promoting a cure for this disease.
12 If the preventive services are to be expanded, an
13 assured source of income will have to be obtained. This
14 could be provided by the Health Grant, if the Grant was
15 made outright and I should say stabilized.

16 10. Personnel to staff the preventive services
17 will become even more acute in the years ahead. Canadian-
18 trained physicians, nurses and technicians are not
19 entering the field of tuberculosis today. Eventually
20 more use will have to be made of the family doctor in
21 supervising post-sanatorium drug treatment, examination
22 of contacts, and examination of ex-patients.

23 11. Treatment services, as presently financed
24 in Saskatchewan, are becoming an ever-increasing burden
25 to the municipal governments. If the cost of treatment
26 of tuberculosis was included under the Hospital Services
27 Plan, this burden would be removed from the municipalities.

28 THE CHAIRMAN: By that you mean that it
29 would become a shareable cost under the Hospitalization
30 Plan?



1 DR. BARNETT: Yes.
2 12. Treatment facilities should be located in
3 the larger urban centres in view of the fact that these
4 centres remain the last stronghold of tuberculosis. It
5 is more economical if the preventive services can be
6 associated with the treatment services. There can then
7 be a sharing of facilities (X-ray, Laboratory, etc.)
8 and personnel (doctors, nurses, technicians).

9 THE CHAIRMAN: Thank you very much,
10 Dr. Barnett. Would you in this term of the patient
11 load in the sanatoria becoming less, would you go so
12 far as to say that the preventive services must be
13 continued at pretty well the same level, even though
14 there were no patients in the sanatoria?

15 DR. BARNETT: Yes, we still must protect
16 the unexposed population from this one case.

17 THE CHAIRMAN: Is there any notion
18 that the community as such can develop an immunization
19 to the disease, to the point where it might be sort of
20 forgotten, I mean forgotten in terms as being a disease?

21 DR. BARNETT: Not as such. We have a
22 vaccine available for immunization, called B.C.G.
23 Mass vaccination was tried by the League in 1951, 1952
24 and 1953, when we did whole municipalities. It is a
25 good vaccine, and gives a very good protection and is
26 recommended in areas where your infection is high, like
27 undeveloped countries such as India. It is highly
28 recommended in a country, or a community where the rate
29 of infection is low. Some question is raised whether
30 you are justified to go out and vaccinate everybody. We



1 are taking the far North area of our Province, north
2 of Prince Albert ---

3 THE CHAIRMAN: That is the area where the
4 Indian population percentage would be highest?

5 DR. BARNETT: That is right. We are
6 vaccinating new born infants at all the out-post hospitals
7 up there. We supply the vaccine and train the public
8 health nurse up there to administer it, but this is
9 considered a higher than average infection environment
10 than the southern half.

11 THE CHAIRMAN: I take it that you know
12 Dr. Wherrett?

13 DR. BARNETT: Very well.

14 THE CHAIRMAN: It may be of interest to
15 you, if you have not already heard it from him. This
16 Commission has commissioned Dr. Wherrett to do a special
17 study of tuberculosis for the Commission, and a brief
18 such as yours here today would naturally go direct to
19 Dr. Wherrett's study for his assistance, and I am quite
20 sure that he will be getting in touch with you.

21 DR. BARNETT: He has spoken to me. I
22 sent him a copy of my brief also.

23 THE CHAIRMAN: So that in this sense,
24 Dr. Wherrett in these areas where we have set up special
25 studies, the Commission itself does not enter into detailed
26 questioning of the brief, much of it is very technical,
27 so you will understand why there will be some cases where
28 we practically just receive a brief and pass it on.

29 DR. BARNETT: Yes.

30 THE CHAIRMAN: There may be some questions



stage would be identical.

What is it? We are

up there. We supply the vaccine and train the public

health nurse up there to administer it, but this is

considered a system of an average level of environment

than the average level

THE CHAIRMAN: I am not sure that you know

THE CHAIRMAN: In any of the interest in

you have not really been to the office

Commission has some interest in, and it is a special

study of experience for the Commission and a brief

such as your own body was a naturally to direct to

Dr. Wheeler's study on his side, and I am going

some that he will be going in to see when you.

Dr. Wheeler: He has asked to see

send him a copy of my first study.

THE CHAIRMAN: I am in this study,

Mr. BARNETT: Yes.

THE CHAIRMAN: There may be some question



1 here, nevertheless, some of the Commissioners may wish
2 to ask.

3 COMMISSIONER VAN WART: Were you here
4 early in the afternoon, when I was talking to the drug
5 people?

6 DR. BARNETT: Yes.

7 COMMISSIONER VAN WART: How are drugs
8 supervised in the sanatoria?

9 DR. BARNETT: They are under usually
10 the supervision of a physician. The Fort Qu'Appelle
11 Sanatorium, the Medical Superintendent is directly
12 responsible for the dispensary. At the Saskatoon
13 Sanatorium I believe a Superintendent nurse assumes this.

14 COMMISSIONER VAN WART: In both cases they
15 actually dispense the drugs?

16 DR. BARNETT: No, they supervise it.

17 COMMISSIONER VAN WART: Who dispenses
18 the drugs?

19 DR. BARNETT: It is a lay person who
20 dispenses the drugs, other than narcotics.

21 COMMISSIONER VAN WART: Not even a
22 nurse?

23 DR. BARNETT: No. For the distribution
24 of our three major drugs, these are distributed by a
25 lay person to the wards.

26 COMMISSIONER BALTZAN: I know the work
27 of the Anti-Tuberculosis League in Saskatchewan right
28 from the day of its inception, and I glory in your
29 success. I know your problems, and I think now we
30 may say to you we will concentrate in helping in the



1 solution of some of your newer problems that are concerning
2 you. I have no questions.

3 THE CHAIRMAN: Thank you very much,
4 Dr. Barnett and Mr. Froh.

5 DR. BARNETT: I would like to thank the
6 Commission for their time.

7 THE CHAIRMAN: We will take a short break
8 before the next matter, which will be the Canadian
9 Public Health Association.

10

11 ----A SHORT RECESS

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1 SUBMISSION OF THE SASKATCHEWAN BRANCH OF THE
2 CANADIAN PUBLIC HEALTH ASSOCIATION

3
4 APPEARANCES:

5 Mr. E. L. Abbott - Secretary of the Branch, a
6 professional public health
7 educator and Assistant Director
8 of the Health Education Division
9 of the Provincial Department of
10 Public Health.

11 Dr. M. S. Acker - Member of the Executive of the
12 Branch, a physician and the
13 Director of Regional Health
14 Services in the Department of
15 Public Health.

16 Dr. Robert Bradley - Member of the Executive, Chairman
17 of the Committee which prepared
18 this Brief. a physician and
19 barrister-at-law and the Regional
20 Medical Health Officer of the
21 Swift Current Health Region.

22 Mr. A. V. Kipling - Member of the Branch, a farmer
23 and the Chairman of one of the
24 Regional Health Boards in this
25 Province.

26 Mr. Stanley Rands - Member of the executive, a
27 psychologist and the Deputy
28 Director of the Psychiatric
29 Services Branch of the Department
30 of Public Health.

Dr. Hugh E. Robertson - Past-President of the Branch,
a laboratory scientist and the
Director of the Provincial
Laboratories in the Department
of Public Health.

Miss Vera Spencer - Member of the Executive of the
Branch, a nurse and a Nursing
Consultant in the Division of
Nursing Services in the Depart-
ment of Public Health



1 Dr. Ralph Sutherland - Member of the Branch and of the
2 Committee set up to prepare this
3 Brief; physician and Medical
4 Consultant to the Saskatchewan
5 Hospital Services Plan.

6 Mr. Alexander Robertson - President of the Branch,
7 a physician and Professor
8 of Social and Preventive
9 Medicine in the University
10 of Saskatchewan.

11 ---EXHIBIT No. 92: Submission of the Saskatchewan
12 Branch of the Canadian Public
13 Health Association.

14 --- EXHIBIT No. 92A: Document entitled "A Submission to
15 the Advisory Planning Committee on
16 Medical Care by the Saskatchewan
17 Branch of the Canadian Public
18 Health Association".

19 MR. A. ROBERTSON: With your permission
20 I will not read our Brief in whole but I will indicate to
21 you the nature of the concern of this Branch with the
22 health services of Canada with which you are also concerned;
23 I will present some of the main contents, conclusions and re-
24 commendations of our Brief; and we shall then remain at
25 your disposal for questioning.

26 You are already familiar, Mr. Chairman, with
27 the nature of our parent body, the Canadian Public Health
28 Association; but with respect I beg to quote the opening
29 sentences of the statement laid before you by that body
30 at your preliminary hearing in Ottawa on September 27th.

"The Canadian Public Health Association is a
national organization with eight provincial



Dr. Ralph Richardson - Member of the Branch and of the
Committee set up to prepare the
Bill: (Physician and Medical)

Mr. Alexander Robertson - President of the Branch,
a physician and Professor
of Surgery and Preventive
Medicine in the University
of Saskatchewan.

---EXHIBIT No. 12: Substitution of the Saskatchewan

Document entitled "A Substitution to
the Bill: (Physician and Medical)
Branch of the Saskatchewan
Health Association."

MR. A. ROBERTSON: With your permission

I will not read our Bill in whole but I will indicate to

you the nature of the contents of this Branch with the

best interests of Canada with which you are also concerned

I will present some of the main essential considerations and so

commentations of our Bill; and we shall then remain at

your disposal for questioning.

The nature of our present body, the Canadian Public Health

Association; but with respect I beg to quote the opening

sentences of the statement laid before you by that body

at your preliminary hearing in Ottawa on September 27th.

"The Canadian Public Health Association is a



1 branches or affiliated associations. For
2 over fifty years, it has been concerned with
3 the conservation and improvement of the health
4 of the people of Canada. Its members belong
5 to all disciplines concerned with the health of
6 the people of Canada and include physicians,
7 dentists, veterinarians, engineers, laboratory
8 scientists, nurses, statisticians, health educators,
9 sanitary inspectors and others. Among its members
10 it numbers persons engaged in official health
11 agencies at all levels of government, as well
12 as professional and technical persons who are
13 engaged in the broad area of health services,
14 plus a number of interested people who are con-
15 cerned with the general health and well being
16 of the public. In 1960, the Government of
17 Canada granted it a new Charter which states:
18 'The objects of the Association shall be the
19 development and diffusion throughout Canada
20 of the knowledge of public health and preven-
21 tive medicine and all other matters and things
22 appertaining thereto, or connected therewith.'
23 "This broad definition is in keeping
24 with the changing concepts of public health.
25 During the lifetime of the Association great
26 progress has been made in the traditional areas
27 of public health such as the control of com-
28 municable diseases and the management of a
29 sanitary environment. The Association feels
30 that it has a much wider interest than the areas



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the people of Canada and their physicians,

scientists, nurses, statisticians, health education, sanitary inspectors and others. Among its members

it numbers persons engaged in official health agencies at all levels of government, as well as professional and technical persons who are engaged in the broad area of health services. plus a number of interested people who are concerned with the general health and well being

of the public. In 1960, the Government of Canada granted it a new charter which states: 'The objects of the Association shall be the development and diffusion throughout Canada of the knowledge of public health and preventive medicine and all other matters and subjects pertaining thereto, or connected therewith.'

This broad definition is in keeping with the changing concepts of public health. During the lifetime of the Association great progress has been made in the transitional areas of public health such as the control of communicable diseases and the management of

that it has a much wider interest than the area



1 usually associated with public health and that
2 it has a vital interest in all matters which
3 concern the health of the people of Canada in-
4 cluding prevention, treatment and rehabilitation."

5 We, Sir, represent one of the eight
6 provincial Branches referred to in the statement which I
7 have just read to you.

8 The group appearing before you today re-
9 presents a cross section of those wide professional in-
10 terests embraced by the Association: a group of nine, of
11 whom four are physicians; one a nurse, one a health
12 educator, one a lay member of a health board, one a pro-
13 fessional psychologist, and one a laboratory scientist.
14 We may perhaps claim in our composition to cover at least
15 a proportion of the membership's interests. Our Brief
16 has been approved by the Executive of the Branch which
17 has seventeen members, who act on behalf of the Branch's
18 approximately 250 total active membership in this Province.

19 The general nature of this Brief is such
20 as to complement, and in some areas to expand upon, the
21 basic recommendations of a previous Brief submitted by
22 this Branch to the Advisory Planning Committee on Medical
23 Care of the Province of Saskatchewan one year ago. That
24 Brief, of which we should be happy to submit a copy to
25 the Commission, recommended five main things. It re-
26 commended that:

27 1: A medical care plan for Saskatchewan should
28 be health-oriented and as comprehensive as
29 medical resources allowed:

30 2: a medical care plan should place strong

it has a vital interest in all matters which
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We, Sir, represent one of the

Provincial Branches referred to in the statement which I

have just read to you.

The group appearing before you today re-

ports submitted by the Association: a group of nine, of

whom four are physicians, one a dentist, one a health

educator, one a lay member of a health board, one a pro-

fessional psychologist, and one a laboratory scientist.

We may perhaps claim to be a group of people of high

status in the membership of the Association, and with

has been approved by the Executive of the Branch which

has so often been the case in the past of the Branch's

approximately 250 total active membership in this Province.

The general nature of this Brief is such

as to be comprehensive, and to show how to expand upon, and

basic recommendations of a previous brief submitted by

this Branch to the Advisory Planning Committee on Medical

care of the Province of Saskatchewan one year ago. That

Brief, of which we should be happy to submit a copy to

the Commission, recommended five main things. It was

summarized thus:

1. A medical care plan for Saskatchewan should

be health-oriented and as comprehensive as

medical resources allowed:

2. A medical care plan should place stress



1 emphasis on preventive services;

2 3. the health benefits should be available
3 to all residents and that financial sup-
4 port should be compulsory;

5 4. the basic structure of the plan should
6 rest upon a strong and effective family
7 physician service with provisions for
8 referral to a well-organized specialist
9 or consultant service;

10 5. a medical care plan should make provision
11 for a variety of measures to maintain and
12 enhance the standard of medical care.

13 That Brief, submitted in December 1960, was
14 subsequently endorsed by an unanimous vote of the
15 Association as a whole at its Annual Meeting in 1961.

16 In the Brief presently before you Mr. Chairman,
17 the Branch has specifically not attempted to make a compre-
18 hensive survey of the whole field of health services.

19 "It makes no pretense", and here I quote from
20 our preamble, "to being a comprehensive survey of anything,
21 but rather purports to represent the thinking and ex-
22 perience of the membership on selected topics, emphasizing
23 matters of special concern to us."

24 It will take but a moment, Sir, for me to go
25 over a summary of our main conclusions and recommendations
26 and this I beg leave to do.

27
28 SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

29 This Branch of the Canadian Public Health
30 Association considers that the time is most opportune



1 to carry out a searching examination of the state of
2 health care for our nation. Such an enquiry into the
3 strengths and weaknesses of our health services - leading
4 to positive recommendations - can have a profound effect
5 on the future well-being of all Canadians.

6 9. We recommend an integrated health and welfare
7 service, satisfactorily fulfilling the following con-
8 ditions of comprehensiveness:

9 I think it is important to stress the fact
10 we recommend an integrated health and welfare service
11 in this connection.

12 "First, an inclusive plan, with continuity of
13 service through the stages of health and apparent
14 health, acute illness, convalescence and prolonged
15 illness, whether disabling or not.

16 "Second, full coverage of all types of personal
17 health services, that is, service by physicians,
18 including specialists as well as generalists,
19 by dentists, including general practitioners and
20 specialists, by pharmacists, by professional and
21 practical nurses, and by all other professional
22 and auxiliary personnel necessary for effective
23 health coverage.

24 "Third, full coverage of service at the home
25 of the patient and at office, clinic, general
26 hospital, special hospital, and institution for
27 long term care.

28 "Fourth, provision of service in the amount
29 required.

30 "Fifth, provision of service for the period required.



1 "Sixth, high quality of all services rendered."

2 (Quoted from Franz Goldmann, Associate
3 Professor of Medical Care, Emeritus, Harvard School
4 of Public Health in "Rounding out the Services
5 in Organized Medical Care Programs"; Proceedings
6 of the Group Health Institute of 1959, Group
7 Health Association of America, New York.)
8

9 10. and It is our belief that the financing of the
10 public's health should be on the basis of individual
11 ability to pay. We do not contemplate a program of
12 insurance, but rather one of comprehensive health services.
13 If you wish us to speak of this distinction, which we
14 consider a very important one, several members of our
15 group will be happy to do so. This service would be
16 provincially planned but would embrace a large element of
17 regional decentralization.

18 11. Based on experience of other programs, we
19 take the view that the feature of a planned health service
20 that is most likely to be remiss is that of the quality
21 of the service rendered. For this reason, quality of
22 care should be a central consideration in all planning,
23 and much of the material of this brief is considered in
24 its relation to quality of care.

25 Again, sir, we have quite an extensive section
26 on quality control measures, and members of the group
27 will be happy to expand this, if you wish.

28 12. While an integrated health and welfare service
29 forms the chief constructive recommendation of this brief
30 some members have offered to our Committee detailed

...quality of all services rendered."

(Quoted from Frank Goldman, Associate

of Public Health in "Founding our the Services
in Organized Medical Care Programs"; Proceedings
of the Group Health Institute of 1957, Group
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It is our belief that the financing of the

public's health should be on the basis of individual

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forms the chief constructive recommendation of this paper

some members have offered to our Committee detailed



1 appraisals of various special aspects of health service
2 organization. That is to say, we circulated our
3 membership in connection with the preparation of this,
4 and there were certain particular things highlighted in
5 the returns. For example, the plight of dentistry
6 in this Province is outlined. Thus the plight of
7 dentistry in this Province is outlined and specific
8 recommendations made (Appendix I). A note has been sub-
9 mitted, and here in part reproduced (Appendix II) on the
10 position of unqualified practitioners should we adopt
11 a plan for total health care.

12 THE CHAIRMAN: Unqualified practitioners?

13 DR. A. ROBERTSON: Non-medical
14 practitioners.

15 THE CHAIRMAN: They would be qualified
16 in their view?

17 DR. A. ROBERTSON: Yes, sir.

18 13. Although some aspects of health service
19 have thus been expanded disproportionately in this brief,
20 others - as, for example, the financial aspect - have
21 received much less attention. If I may so, with
22 respect, they received very little attention, and we
23 would not set ourselves up as finance experts or experts
24 on the tax structure of Canada. This is not to deny
25 their importance, but to recognize that the financing
26 of health services has been studied extensively, and
27 that this Branch does not believe that it can profitably
28 add to the already voluminous literature on the subject.

29 14. However, despite the interest of some
30 members in specialty sections of health services, our



appraisals of various aspects of health service organization. That is to say, we circulated our membership in connection with the preparation of this, and there were certain particular things highlighted in the returns. For example, the plight of dentistry in this Province is outlined. The plight of dentistry in this Province is outlined and specific recommendations made (Appendix I). A note has been submitted, and here in part reproduced (Appendix II) on the position of unqualified practitioners should we adopt a plan for total health care.

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However, despite the interest of some members in specialty sections of health services, our



1 chief recommendation is that at regional level there
2 should be an integrated service of health promotion,
3 medical care, community planning, and social welfare,
4 combining their resources in a total approach to problems
5 of health and welfare."

6 Mr. Chairman, it is in the nature of a pro-
7 fessional association such as ours, that those who re-
8 present it will wear many hats. In addition to our
9 roles and functions as members of this Branch each of us
10 is employed or occupied in one or other capacity as a
11 member of a public body, a provincial or municipal civil
12 servant or a member of an University; for none of these
13 institutions do we speak today, but only as representa-
14 tives of our common professional association.

15 A distinguished member of your own profession
16 Mr. Chairman, Mr. Wendell Berge, a one-time Deputy
17 Attorney General of the United States once wrote a
18 classic paper on "Justice and the Future of Medicine".
19 In that paper, given in 1945, he defined and drew certain
20 comparisons between what he called the "technology" and
21 "the organization" of medicine. By the "technology"
22 he meant all of those arts of internal medicine, surgery,
23 radiology, and the like which constituted the profession
24 of medicine. By "the organization" he meant, and I
25 quote "all of those arrangements, social and economic
26 whereby medical service is made available." These
27 two definitions have passed into the common parlance
28 of the public health profession as valid distinctions
29 to make. That there could be no "organization"
30 without the "technology" he readily admitted: but he



AMERICAN MEDICAL ASSOCIATION
OFFICE OF THE SECRETARY
535 N. Dearborn Street, Chicago, Ill.

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1 stressed that the technology was of no value without
2 there were proper social and economic arrangements whereby
3 it could be conveyed to those who required it.

4 All of us here today are concerned primarily
5 with "the organization of medicine" as defined by
6 Wendell Berge: with all of those arrangements social and
7 economic whereby medical service is made available. We
8 of the Saskatchewan Branch of the Canadian Public Health
9 Association have the honour to represent before you the
10 professional association of those who have made that
11 "organization" their study and their concern.

12 THE CHAIRMAN: I am going to accept
13 your first offer to have someone expand paragraph 10
14 where you say it is your belief that the financing of
15 the public's health should be on the basis of individual
16 ability to pay.

17 DR. ACKER: Mr. Chairman, you are
18 interested in the first sentence?

19 THE CHAIRMAN: No, I am interested in
20 the first paragraph. I would not want to take the
21 sentence out of context.

22 DR. ACKER: Well, Mr. Chairman, I think
23 the point here is that what this brief contemplates
24 is not merely a form of what you might call sickness
25 insurance; that is, primarily the need to finance a
26 personal health service per se or as such. We think of
27 it rather in terms of health service, the organizational
28 aspects and components of such a service, and the ways
29 in which the elements of health service can meet the
30 health needs of our people in Canada, and constantly be



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health needs of our people in Canada, and constantly be



1 ready to move in new directions as those needs change
2 and as we have observed them change in recent years.
3 I think it is interesting to observe that many years ago,
4 towards the end of the last century when health insurance
5 was first promoted in certain European countries, medical
6 science and medical technology was rather limited,
7 so that the insurance concept as well was limited; but
8 today modern medical care plans must be designed to
9 promote the health of people, of preventive services, to
10 reduce if not prevent those diseases and serious stages
11 of those diseases by effective treatment following early
12 diagnosis, and it seems to us, Mr. Chairman, that the
13 plans which fail to lay a foundation for the achievement
14 of these objectives is really sickness insurance in
15 the sort of 19th century vintage, if you like, even
16 though they are sometimes advertised and referred to
17 as health programs. That, sir, briefly is really the
18 general meaning of that paragraph.

19 COMMISSIONER STRACHAN: I don't think
20 that Dr. Acker has explained the basis of individual
21 ability to pay.

22 DR. ACKER: Well, Dr. Strachan, I was
23 really taking, I suppose, the paragraph in totality,
24 That first sentence --- I can expand briefly on that:
25 simply that the financing of a health service in general
26 should draw its sources of funds from the national
27 production, if you like, and from individuals directly
28 or indirectly in relationship to individual and family
29 income, as in contradistinction to a flat premium basis
30 which is often done in many prepayment plans in this



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of those objectives is really almost impossible in
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as health programs. That, sir, briefly is really the
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that Dr. Acker has explained the part of individual
ability to pay.
DR. ACKER: Well, Dr. Steenson, I was
really taking, I suppose, the paragraph in totality,
That first sentence --- I can expand briefly on that;
simply that the financing of a health service in general
should draw the sources of funds from the national
production, if you like, and from individuals directly
or indirectly in relationship to individual and family
income, as in contribution to a flat premium rate
which is often done in many prepayment plans in this



1 country and elsewhere. I think that is essentially
2 what "individual ability to pay" means.

3 COMMISSIONER STRACHAN: You are still
4 recognizing the fact that the individual must pay for
5 his health services to some degree?

6 DR. ACKER: I suppose in the end we all
7 do in one form or another.

8 THE CHAIRMAN: You contemplate here
9 that the State will be the collector and the payer?

10 DR. ACKER: Yes.

11 THE CHAIRMAN: And that the individual
12 is not going to pay for each item of service that he
13 receives?

14 DR. ACKER: Correct.

15 COMMISSIONER STRACHAN: I cannot help
16 but pass some remark on the recognition of the dental
17 problem in Appendix I. First of all, you recommend
18 that there should be more dental schools established
19 but some in your group heard the Minister say the other
20 day that there were no plans or intention of a school
21 in this Province so that is not a very great solution
22 to this dentist situation?

23 DR. A. ROBERTSON: We regret very much
24 that the dental service in the Province is not able
25 to do that. Dr. Bradley will be glad to answer any
26 questions on dentistry.

27 COMMISSIONER STRACHAN: I do not think it
28 would change anything from what we heard the other day.

29 THE CHAIRMAN: Regardless of that,
30 is it your thought there should be some activity elsewhere?



recognizing the fact that the individual went out for
his health services to some degree?

DR. ADAMS: I suppose in the end we all
do in one form or another.

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DR. ADAMS: Yes.

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is not going to pay for each item of service that he

DR. ADAMS: Correct.

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would change anything from what we heard the other day.

THE CHAIRMAN: Regardless of that.

is it your thought there should be some activity elsewhere



1 DR. BRADLEY: Yes, but then they tend
2 to develop affiliations with other persons and practise
3 there so in the longer term we would hope we would have
4 a dental school in this Province and so recommend.
5 Meantime, we think our best approach is through the
6 recruitment of dental nurses as has been tried else-
7 where successfully. This would take some planning,
8 some time to organize. We have in mind a dental nurse
9 who was working with 500 children who would have about
10 two years of training and be able to do more than merely
11 hygienists work. The present basis, of course, is we have
12 hygienists but unfortunately we have very few of
13 them. In my own health region the employment of the dental
14 hygienist has been, very, very successful, she has
15 been able to apply topical fluoridewhere fluoridation
16 was not possible on a community scale through the water
17 system. She has been able to examine these and recommend
18 attention by dentists where it is urgently needed. The
19 main theme of our brief is, of course, regionalization.
20 This is something to attract dentists into areas. I do
21 not know how much emphasis to place on this but it
22 certainly is a fact that for 56,000 people in our region
23 we have a total of 13 dentists and that is better than
24 the nationwide average across Canada. In the case of
25 children, not in the case of adults, we have four dentists
26 employed at the Swift Current Health Region Board who
27 take care of the children's teeth up to the age of 12.
28 We have nine practising dentists in that region.

29 COMMISSIONER STRACHAN: Nine private
30 practices?



1 DR. BRADLEY: Yes.

2 COMMISSIONER STRACHAN: That makes up the
3 13?

4 DR. BRADLEY: For 56,000.

5 THE CHAIRMAN: Most of them are in
6 Swift Current?

7 MR. BRADLEY: Yes, most of them in Swift
8 Current City.

9 COMMISSIONER STRACHAN: Your reference
10 to the ratio of dentists to population, I notice you
11 refer to the two provinces that are better off than you
12 are locally but I am sure you are aware of the situation
13 in Newfoundland where it is one to 10,000.

14 DR. BRADLEY: Yes.

15 THE CHAIRMAN: I observe in paragraph 132,
16 and this is still on the question of dentistry, you
17 quote from the Sigerist Commission of 1944, in that
18 section dealing with dentistry where the following appears:

19 "Dental conditionals are appalling in this province.
20 A large percentage of the population has no dental care
21 whatsoever and the overwhelming majority of the people
22 has not sufficient dental care."

23 If you were describing the situation in
24 Saskatchewan today, would you use the same language or
25 different language?

26 DR. BRADLEY: I would use the same
27 language, but, of course, it is comparative. Once the
28 dental care scheme has been effectively put into
29 operation with children it is almost entirely possible
30 to exclude removing the sixth year molar. In the New



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1001 STRACHAN: That makes up the

MR. BATHURST: For \$2,000.

THE CHAIRMAN: Most of them are in

MR. BATHURST: Yes, most of them in Swift

Current City.

COMMISSIONER STRACHAN: Your reference

to the matter of land to be given, I notice you

refer to the two questions that are before you and you

are locally but I am sure you are aware of the situation

MR. BATHURST: Yes.

THE CHAIRMAN: I observe in your report 1931

and this is really on the question of land, is it

drawn from the 25,000 acre tract of 1944, in that

section dealing with land, where the following appears:

"Partial acquisition was effected in 1944 by the

A large percentage of the population has been at work

was secured and the overwhelming majority of the people

has not sufficient capital.

If you are describing the situation in

Switzerland today, would you use the same language on

MR. BATHURST: I would use the same

language, but, of course, in a comparative sense, the

social care scheme has been effectively set back

operation with children is almost entirely possible



1 Zealand scheme after they had been going for about 23
2 years they removed only one permanent tooth and that
3 pretty well means the sixth year molar, one for every
4 261 children treated. This is quite a reasonable level.
5 Looked at slightly different, in 1921, when the New
6 Zealand scheme was introduced the ratio of extractions
7 by our patients was 114.5 extractions to every one hundred
8 patients. Leaving out a fair number of statistics the
9 position recently is that only four extractions are done
10 for 100 patients, so that improvement is considerable.

11 THE CHAIRMAN: In the areas where there
12 has been --

13 DR. BRADLEY: Where this was introduced.
14 It is comparative, of course, when you say that conditions
15 are appalling; they are bad even in Swift Current where
16 I think they would be better and in the Province generally.

17 THE CHAIRMAN: Even in 1944 at the time
18 of the Sigerist investigation and report that there
19 had been a well developed school dental program in
20 Saskatoon for almost 20 years prior to that time covering
21 grades one to eight, the entire elementary system. Even
22 then he said conditions were appalling.

23 DR. BRADLEY: Yes.

24 DR. A. ROBERTSON: The word "appalling"
25 is a state of affairs having to do with dental health
26 in most parts of the civilized world today.

27 THE CHAIRMAN: So we know what happens
28 with the rest of them.

29 DR. A. ROBERTSON: There are some that
30 are better.



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8 patients, leaving out a fair number of statistics for
9 position recently in fact only four extractions are done
10 for 100 patients, so that improvement is considerable.
11 THE CHAIRMAN: In the areas where there

12 has been --
13 DR. HADDAD: Where there has been improvement.
14 It is comparative, of course, when you say that conditions
15 are appalling; they are not even in some of the worst areas
16 I think they would be better and in the Province generally.
17 THE CHAIRMAN: In 1944 at the time

18 of the St. George's investigation and reports that there
19 had been a well developed school dental program in
20 Auckland for almost 20 years prior to that time covering
21 grades one to eight, the entire elementary system. Even
22 then the said conditions were appalling.

23 MR. HADDAD: Yes.
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25 is a state of affairs having to do with dental health
26 in most parts of the civilized world today.

27 THE CHAIRMAN: So we know what happens
28 with the rest of them.
29 MR. A. ROBERTSON: There are some times



1 DR. BRADLEY: There are some that are
2 better. I would describe as appalling any system of
3 dental care which does not preserve the permanent teeth
4 in good alignment. That is a doctor's view and I am
5 well aware there is a dentist on the Commission.

6 COMMISSIONER STRACHAN: That is a physician's
7 view?

8 DR. BRADLEY: Yes.

9 COMMISSIONER VAN WART: Speaking about
10 dentistry, I notice in section 82 you mention the
11 appalling conditions and you go on to section 83 and
12 advocate availability of bursaries and scholarships and
13 then you come up with the idea of post-graduate employ-
14 ment, your vocations committee and then you have in
15 brackets "Along the line of the present policies of
16 the Government of Newfoundland". Is that the principle
17 of cottage hospitals that you have in mind, the employ-
18 ment of doctors or dentists associated with it?

19 DR. SUTHERLAND: The Government has been
20 providing sums of money to students in the four years
21 but there has been a vocational commitment on graduation,
22 their commitment being four years, two years in the
23 cottage system and two years in any form of practice
24 in Newfoundland which completely resolved the debt which
25 would have been \$4800.00. I am not saying this is the
26 sort of thing which should apply, I merely use it
27 as an example of a province increasing its medical
28 personnel by tying financial support to post-graduate
29 commitment.

30 THE CHAIRMAN: They seem to be satisfied

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DR. BRADLEY: Yes.

COMMISSIONER VAN WART: Speaking of

dentistry. I notice in section 63 you mention the appalling conditions and you go on to section 64 and advocate availability of courses and scholarships and then you come up with the idea of post-graduate employment, your vocational committee and then you have in brackets "Along the line of the present practice of the Government of Newfoundland, is that the principle of cottage hospitals that you have in mind. The employment of doctors or dentists associated with it."

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THE CHAIRMAN: They seem to be satisfied



1 with the way it has worked out.

2 COMMISSIONER VAN WART: As I recall,
3 they were having difficulty getting people to take the
4 bursaries. As we went to cottage hospitals we noticed
5 that the doctors were not natives of Newfoundland, they
6 were from other parts of the world. The bursary
7 system is there but they do not think it has been taken
8 up for the same reason as the bursaries in Saskatchewan.
9 We are told they are not popular and also in Manitoba be-
10 cause of the stipulation they must go to certain areas
11 when they have finished their studies for which the
12 bursary was given. For that reason they would not
13 accept it, they had difficulty in getting bursary
14 students. We heard this last night also.

15 DR. SUTHERLAND: My comment would be
16 for either Newfoundland or here. They have still
17 increased the available personnel by some percentage
18 and it is again to the people using them. In other
19 words, if the Government has only three physicians that
20 they would not have had without the plan, it is still
21 a gain of three doctors.

22 COMMISSIONER VAN WART: The bursary
23 system in the V.O.N. has been very successful because
24 they are not designated to go to a certain area, they
25 are assigned wherever the Order sends them and very
26 often it is out of the Province altogether where they
27 took their bursary. This has been very successful.
28 However, these bursaries that have a definite assignment
29 to them have not been so successful, that is what
30 we have been told across the country.



1 With the way things worked out.

2 COMMISSIONER VAN WART: As I recall,

3 they were having difficulty getting people to take the

4 burseries. As we went to cottage hospitals we noticed

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26 often it is out of the province altogether where they

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28 However, these burseries that have a definite assignment

29 to them have not been so successful, that is what

30 we have been told across the country.



1 DR. SUTHERLAND: I can relate this to the
2 hospital administration type of support under the
3 Federal educational grants in aid of the amount of use
4 the provinces have been able to get or the amount of
5 benefit the provinces have been able to derive from these
6 grants. To some extent it is related to the kind of
7 area. In some provinces if they were to receive this
8 support in hospital administration you must have a
9 commitment from some hospital to accept you for some
10 employment for a period of three years after graduation;
11 this means both you and the hospital accept in advance
12 something you do not know you would like. The absolute
13 requirement is to do three years in the Province, you
14 could work for an insurance program or a hospital or
15 a government, et cetera, the commitment specification
16 in terms of specificity may affect you. Naturally the
17 student will not become tied to this commitment. I
18 do not wish to make this a big issue.

jb 2 19 COMMISSIONER VAN WART: The difficulty
20 is when they take it on condition they go to retarded
21 areas where you need people to go, the bursary system
22 has not worked out well.

23 THE CHAIRMAN: That is a matter of
24 interpretation. It is not entirely my recollection of
25 what we have heard. I think our function is to obtain
26 information from you and not give all sorts of information
27 or attempt to add to your qualifications because we
28 are not qualified to do that.

29 DR. A. ROBERTSON: I might add one word
30 about this business of ---



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1 DR. SUTHERLAND: I can relate data to the
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4 the provinces have been able to get on the amount of
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7 areas. In some provinces if they were to receive this
8 support in hospital administration you must have a
9 commitment from some hospital to accept you for some
10 employment for a period of three years after graduation.
11 This means that you are the staff of a hospital in advance
12 something you do not know you would have. The absolute
13 requirement is to do three years in the Province. You
14 could work for a research program or a hospital or
15 a government, or several. The commitment is specified
16 in terms of specialty may affect you. Naturally the
17 student will not become tied to this commitment. I
18 do not wish to make this a big deal.
19
20 COMMITTEE: I am with you. The difficulty
21 is when they take it as condition they go to related
22 areas where you need people to run the primary system
23 and not wanted and all.
24
25 Interpretation. It is not entirely my recollection of
26 what we have heard. I think our question is to obtain
27 information from you and not have all sorts of information
28 or attempt to add to your qualifications because we
29 are not qualified to do that.
30
31 DR. A. ROBERTSON: I might add one word
32 about this business of --



1 THE CHAIRMAN: I want to put a question
2 directly on the subject; has it been the experience of
3 you gentlemen that conditional loans or bursaries has
4 been a detriment to it being accepted by anybody in
5 Saskatchewan?

6 DR. A. ROBERTSON: On occasions it has,
7 sir, but I think we would endorse what Dr. Sutherland
8 said; even if it only works to provide a very limited
9 number of additional personnel this approach is obviously
10 desirable. I would go back to Dr. Van Wart and say
11 that it depends on different personalities. I think we
12 started that in dentistry and it has not been successful
13 in that regard in this Province.

14 COMMISSIONER VAN WART: The only other
15 comment I wish to make is that on a question of general
16 practitioners your regional unit I understand is about
17 100,000 people and in that you are dependent upon the gen-
18 eral practitioner to carry out most of your procedures?

19 DR. A. ROBERTSON: Most of them.

20 COMMISSIONER VAN WART: And that pre-
21 disposes to a training of a G.P. in public health
22 work, some training or is that necessary?

23 DR. A. ROBERTSON: I am not sure if I
24 get your question correctly. We certainly believe that
25 a physician should be properly grounded in the public
26 health approach to medicine in the course of their under-
27 graduate training.

28 THE CHAIRMAN: You say your plan is
29 based on a regional basis, can you explain just what
30 is involved in what you mean by that in a little greater



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directly on the subject; has it been the experience of

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air, but I think we would expect what Dr. Sturges

said; even if it only looks to provide a very limited

number of additional personnel from abroad is obviously

desirable. I would go back to Dr. Van Wert and say

that it depends on what is contemplated. I think we

are agreed that in delivery and it has not been successful

in that regard in this province

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comment I wish to make is that on a question of general

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based on a regional basis, can you explain just what

is involved in what you mean by that in a little greater



1 depth than we have had?

2 DR. A. ROBERTSON: There were three
3 principle words we used; regionalization, decentralization
4 and co-ordination.

5 MR. BRADLEY: The essence of our brief
6 is we believe that if some form of middle government
7 were to deal with the topic of health and welfare it
8 would do so more effectively than a government by a
9 very small unit and would do so with less fuss, bother and
10 political implications than might be the case if it
11 were some monolithic structure either provincial or
12 national. Therefore, we recommend a regional system
13 of health and welfare consisting of about 100 or perhaps
14 120,000 people. We have in mind it may be six or
15 perhaps seven regions combining health and welfare
16 regions in Saskatchewan and it is our suggestion that a
17 beginning should be made with the administration of
18 health and welfare regions on these lines. It is
19 our belief if the region is identified - I say identified
20 and not created - by a consideration of natural boundaries,
21 the natural flow of trade of this region, which has a real
22 existence; it is not something which is created out of
23 the thought of some plan but already is in existence,
24 would foster the development on the local level of an
25 integrated area. Some people prefer to say co-
26 ordinated instead of integrated. In other words, there
27 would be much less tendency for a family in difficulties
28 to be dealt with, shall we say, at the Department of
29 Social Welfare, a report to go into Regina and then
30 perhaps if we are lucky a report coming back to the region.



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regional. Therefore, we recommend a regional system
of health and welfare on a basis of about 100 or perhaps
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perhaps seven regions comprising health and welfare
regions in Saskatchewan and it is our suggestion that

health and welfare regions on that basis. It is
our belief if the region is identified I say identified
and not created - by a combination of natural boundaries
the natural flow of trade of the region which has a real
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the thought of some plan but already is in existence,
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would be much less tendency for a facility in difficulties
to be dealt with, shall we say, at the Department of
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perhaps if we are lucky a report coming back to the region



1 The matter may be dealt with, we think, if this were
2 co-ordinated at a local level with the regional board
3 which we see as the governing body. We believe this
4 would be much more acceptable to the physicians than
5 the suggestion which was recently made by a committee
6 to the Provincial Government which was the suggestion
7 that the plan could be centrally controlled as far as
8 medical care is concerned. I will go further if
9 requested.

10 THE CHAIRMAN: Go right on.

11 COMMISSIONER VAN WART: In your brief
12 you say that the region should be closely associated
13 with the school.

14 MR. BRADLEY: I do not think you can
15 separate education from health and welfare but,
16 at the same time, owing to the special hospitalization
17 development of schools I would not suggest personally
18 that there should be a combined health and welfare
19 education. I think this would hardly be possible
20 at the moment. Close co-ordination, yes, certainly,
21 but the history of this Province has not been such as
22 to facilitate that extreme type of going together.
23 I believe we are much better to leave the school system
24 as it is with representation in the school system with
25 regional medical health officers. I do not feel any
26 need to touch them, I think it is working well at the
27 moment.

1 28 I don't feel any need to touch that. I
29 think it is working very, very well at the moment. On
30 the other hand, I would like to see very much more close



1 liaison between health and welfare. I practice social
2 medicine. My colleague practices social welfare. I
3 have very great difficulty in putting any hard and fast
4 line between the two, and where an attempt is made to
5 divide these on the local level we find we waste money
6 and run into duplication of staff and duplication of
7 service.

8 THE CHAIRMAN: Doctor, I would like to
9 see you come back to the question we were talking about,
10 and continue, because our purpose in receiving the
11 delegations and hearing from them is to hear ideas, and
12 have principles discussed.

13 Now, this regional idea is not completely
14 novel, but certainly has not been expounded very loudly
15 in this Province up to now, and I am anxious to hear
16 more from you as to the benefits you see from this regional-
17 ization, and from administration at the regional level,
18 and not at this monolithic level, either provincial or
19 federal?

20 DR. A. ROBERTSON: We have between us
21 discussed and compared who shall refer to various parts
22 ---

23 THE CHAIRMAN: I am not necessarily con-
24 fining the answer to any one person. It is just that
25 I didn't want the development of the idea to be over-
26 looked.

27 DR. BRADLEY: The immediate advantages
28 that I believe it would be accepted by physicians and
29 others. Indeed, as far as Swift Current is concerned,
30 I think we have in operation a Region which is acceptable



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that I believe it would be accepted by physicians and

others, indeed, as far as Swift Current is concerned,

I think we have in operation a Region which is acceptable



1 to the people and acceptable to the people who serve
2 the residents. My big argument is that it is feasible.

3 THE CHAIRMAN: You would have six or seven
4 regions. They would administer the program within the
5 region?

6 DR. BRADLEY: Certainly.

7 THE CHAIRMAN: What, if anything, would
8 be above the regions, in the administration structure?

9 DR. BRADLEY: I don't think that you
10 could possibly have taxation on the regional basis.
11 Taxation would have to be I think on as broad as possible
12 bases. Some would say provincial, some would say federal.
13 We do not propose to go into that. We merely say to
14 tax each region as it presently is being done in the
15 case of Swift Current, is sooner or later to get into
16 difficulties. It must necessarily be a land tax. We
17 have a tax of 2.7 mills at the moment. We are going
18 to lose it, we believe, when the Provincial plan comes
19 into operation, and we are very glad to have the tax
20 base broadened, so that is one of the things, very
21 definitely, that we would not handle on a regional basis.

22 The question of standards, too, sir.
23 This could not possibly be dealt with regionally.
24 Standards would necessarily be a matter for the provincial
25 authorities. The plan would be provincially administered
26 to that extent, and in our brief the people who took some
27 time to write on mental health pointed out that there
28 are certain parts of mental health which could not be
29 regionalized, and they chose as an example of that the
30 care of mentally retarded children, and they felt that for



to the people and acceptable to the people who serve
the residents. My big argument is that it is feasible.
THE CHAIRMAN: You would have six or seven

regions?
MR. BRADLEY: Certainly.

THE CHAIRMAN: What, if anything, would
be above the regions, in the administration at, rather?
MR. BRADLEY: I don't think that you

could possibly have taxation on the regional basis.
Taxation would have to be a thing as broad as possible
basically. Some would say that it would say that it

We do not propose to go into that. We merely say in
tax each region as it presently is being done in the
case of Swift Current. It comes on later to get into

difficulties. It must necessarily be a local tax. We
have a tax of 1.5 mills at the moment. We are going
to leave it, we believe, when the Provincial plan comes

into operation, and we are very glad to have the tax
also broadened, so that it is one of the things, very
broadly, that we would not handle on a regional basis.

The question of assessment, too, sir.
This could not possibly be dealt with regionally.

Assessment would necessarily be a matter for the provincial
authorities. The plan would be provincially coordinated
to that extent, and in our plan the people who took some

time to write on mental health pointed out that there
are certain parts of mental health which could not be
regionalized, and they chose as an example of that the



1 various reasons, which they have set out herein, that
2 this is not feasible as a regional proposition.

3 THE CHAIRMAN: Dr. Acker, do you wish
4 to add?

5 DR. ACKER: Mr. Chairman, as you indicated
6 a moment ago, the idea of regionalization is really not
7 new. It has been thought of and developed by, shall we
8 say many thinkers in the field of health service organi-
9 zation for many years, and I imagine your Commission is
10 interested in exploring new ideas, even though they
11 may be something that cannot be immediately translated
12 into a practical program, within any Province or the
13 country as a whole.

14 I would like to refer you to the concept
15 which has perhaps been most amplified by Dr. John Grant,
16 who is quite an international authority in this field,
17 and formerly with the Rockefeller Foundation, has served
18 for half a century in countries like China and India,
19 and is currently in Puerto Rico, where similar types of
20 approaches are attempting to be carried out. His de-
21 finition is set out in our submission and I may read it
22 here. He defines regionalization as the organization
23 and co-ordination of all health resources and services
24 within a defined area for the purpose of maintaining
25 the highest possible level of medical care, and adapting
26 a comprehensive program to the needs of the area.
27 Now, I think if we attempt to translate this into more
28 specific terms, I believe that what is visualized
29 is that heretofore we have seen in the development of
30 health programs sort of fragmentation in our approach.

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to 2002

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new. It has been thought of and developed by people

say many thinkers in the field of health service organi-

zation for many years, and I imagine your Commission is

interested in exploring new ideas, even though they

may be something that cannot be immediately translated

country as a whole.

I would like to refer you to the concept

which has been most widely applied in the field, that

who is doing an international study in this field.

and formerly with the Rockefeller Foundation, has served

for half a century in countries like China and India.

and is currently in Taiwan, where similar types of

approaches are attempting to be carried out. His de-

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and co-ordination of all health resources and services

within a defined area for the purpose of maintaining

the highest possible level of medical care, and adapting

a comprehensive program to the needs of the area.

Now, I think if we attempt to translate this into more

specific terms, I believe that what is visualized

is that therefore we have seen in the development of

health programs sort of fragmentation in our approach.



1 Some services evolve from central initiative, from
2 provincial authorities, and in some cases from federal
3 authorities. For example, in the case of the care of
4 Indians in this country and the various programs also
5 developed a different pace, or speed of development if
6 you like, and they do not necessarily move one in re-
7 lationship to the other.

8 The idea of regionalization is attempts,
9 to remedy this situation. In other words, what we
10 visualize is a means of obtaining the kinds of inter-
11 lacing and working together of the various elements of
12 health care, be they preventive treatment or rehabilitation
13 or whether they stem from what we describe as community
14 public health service, medical care service, or hospital
15 service, which are the main elements, and we would
16 add social welfare service of certain types, because
17 they have such a close relationship and impact upon the
18 health of families and people, and this means that ---

19 THE CHAIRMAN: Doctor, I don't want to
20 cut into the discourse on that. I think we can follow
21 it through on the type of co-ordinated, integrated service.
22 We have got to try to get down a little closer to the
23 ground on this matter of regions. You are suggesting
24 that there be six for Saskatchewan. Why six for
25 Saskatchewan? Why not Saskatchewan as one region,
26 for instance, in terms of administration? I mean,
27 this is the kind of --- I would like to have your views
28 on these practical aspects of regionalization.

29 DR. ACKER: Well, some have argued
30 as a matter of fact that the Province of Saskatchewan,



1 with 916,000 people, could possibly
2 be considered as one region, but I think in this Province,
3 sir, we do have to pay attention to the low density and
4 dispersal of our population, and in order to bring
5 basic services into the various areas of the Province,
6 it appears to our group that one region, which in effect
7 means a completely centralized and unified structure for
8 the whole Province, would not achieve this result, that
9 it would perhaps become too distant from the receivers
10 of service. It would not set a basis for the type of
11 co-ordination between the various elements of service
12 which are required reasonably close to where the people
13 live, and where they work, and where they receive their
14 care, and I think this kind of --- considering the
15 Province in a series of six, seven, or perhaps eight
16 regions, this is something which looks like the manner
17 in which it should be developed, rather than by taking
18 the Province as a whole.

19 THE CHAIRMAN: I suppose there would
20 be some price to pay for that, in increased administration
21 costs?

22 DR. ACKER: Yes, there could very well
23 be.

24 THE CHAIRMAN: And you think that would
25 be worth paying, the price?

26 DR. ACKER: I think we do have to pay
27 the price of increased administrative costs if we want
28 to achieve the best value from the health dollars that
29 the country provides, and achieve the objectives that
30 we desire.



1 THE CHAIRMAN: You would have the ad-
2 ministration in this local region. The tax, I mean
3 the money to support the services in the region would
4 not be raised locally. How would those moneys reach
5 the suppliers, those moneys not having been raised
6 locally, how would the region obtain the resources to
7 pay for the suppliers of service?

8 DR. ACKER: Well, in our submission,
9 sir, we haven't really spelled out any definitive
10 proposal regarding the sharing of costs---

11 THE CHAIRMAN: No, I am talking now of
12 the administration?

13 DR. ACKER: Yes, but your preamble,
14 sir, that there would be perhaps no regional participation
15 in financing. There may very well be some places,
16 for example, in the provision of nurses and home makers
17 services. I would suggest those as a start. However,
18 I think what is implied is that if one assumes that the
19 Province becomes the major administrative authority,
20 or instrument, for a program of this type that the funds
21 would be derived from provincial sources and be granted
22 to areas where service would be actually carried out.
23 There are many ramifications of course.

24 THE CHAIRMAN: Of course you have this
25 in part in Swift Current now, with that in that grant
26 of X dollars, whatever it is?

27 DR. ACKER: Yes.

28 THE CHAIRMAN: If I may move to another
29 matter, in which I think we would appreciate having your
30 views, if you have any view on the subject, and that is



1 as to whether you have any views on the priority or
2 priorities, that ought to be adopted, in terms of different
3 health needs?

4 DR. A. ROBERTSON: We have been quite
5 exercised about this matter of priorities, amongst our-
6 selves, and I think it is one of the most crucial problems.
7 We would be quite anxious to underline the high priority
8 which should go, in our estimation, to what in technical
9 terms we refer to as primary medical care. We are
10 perfectly aware of, as one example, which has been
11 prominent before you recently, the somewhat urgent
12 needs in the field of mental health. We recognize
13 that there are for example needs for new kinds of hospital,
14 and for heavy capital expenditure on mental hospitals.
15 We also recognize with some dismay that some atmosphere
16 in relation to this particular topic has been created
17 to suggest that the mental health services of this
18 Province are, if not appalling, then very bad. They
19 are of course, in the opinion of international experts,
20 third, after Great Britain and Holland. These are
21 necessary, undoubtedly and the time must, and will come
22 soon when great expenditure is necessary upon them.

23 However, our feeling is that the first
24 priority is the ready availability of a high quality of
25 basic medical care service. It is for this reason that
26 we support for example the initial steps taken in the
27 recent legislation in the Province. This is on the
28 grounds of the preventive function of primary medical
29 care. I don't want it to go on at great length if that
30 phrase is comprehensive and satisfactory. In other words,

as to whether you have any views on the priority of

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we support for example the initial steps taken in the

recent legislation in the Province. This is on the

grounds of the preventive function of primary medical

care. I don't want to go on at great length in this

because it is comprehensive and satisfactory. In other words



1 it is conceivable to assume, indeed it must be assumed
2 if medicine is performing the task which it sets out
3 to perform that if primary care is available, then the
4 needs for such things as hospitalization, such things
5 as the mental hospitals for those who require serious
6 treatment will be in less demand if there has been good
7 primary care initially. One of the immediate come-
8 backs possibly on this one is why in this Province was
9 hospitalization put ahead of primary medical care by
10 some 16 years, and of course in international public
11 health service we have recently been put on the carpet
12 on this very subject, along with Dr. Kelly from the
13 C.M.A. --- why did we put, as some of our American
14 friends called it, the cart before the horse? There
15 is a strong body of opinion that believe that we did
16 put the cart before the horse, to which I personally,
17 and this is a personal view, subscribe, but the view
18 of our group as a whole is that primarily medical
19 care is the first base line, after of course the en-
20 vironmental, and specific services already supplied by
21 the public health services.

22 THE CHAIRMAN: Does that primary
23 medical care, in the way the Act reads now, appear to
24 reach into the mental health area to any extent?

25 DR. A. ROBERTSON: Under the terms of
26 the Act it is entirely proper, as I interpret it,
27 for the general practitioner, who is the first port of
28 call in primary medical care, to carry out those forms
29 of, and I have to put this in quotation marks "Preventive
30 Work". Mr. Rands may want to pick us up here, because



1 the provision of an hour's opportunity for consultation
2 between a troubled mother, who may be somebody who
3 has to be prevented from going into a hospital with
4 a psychotic breakdown later, there is strong suspicion
5 that it does do some good, and the general practitioner,
6 the family doctor, who is practising comprehensive
7 medicine, is in fact relieving the problem of expenditure
8 upon mental hospital beds.

9 MR. RANDS: We regard the general
10 practitioner of medicine as the first line of defence,
11 and one of the things that has been sadly lacking in
12 large areas of this Province, and many other places,
13 has been an adequate specialist consulting service
14 to back him up, and guide him in this work. In the
15 sections of our brief dealing with how mental services
16 fit into the local regionalization, we have tried to
17 spell out that the role of the specialist in psychiatry
18 would become the same as the role of other specialties
19 of medicine and would be brought close to the people,
20 and to the local physician by the regional plan. This
21 is one feature of what has been described to you
22 previously as the Saskatchewan Plan.

23 THE CHAIRMAN: Yes, well now, accepting
24 that, as one may easily do, does it involve that there
25 will be a greater demand upon the time of the physician
26 in this expanded field of mental illness?

27 DR. A. ROBERTSON: If the family
28 physician, or the general practitioner, is to fulfill
29 the characteristics that we recognize as comprehensiveness,
30 then yes, probably it does. Let us further qualify this



1 very firmly by two statements. The first is that the
2 modern trained physician, who has been acquainted with
3 public health social medicine and psychiatric approaches
4 in the course of his education is infinitely better
5 equipped to do this than those of us trained before or
6 during the last War. Secondly, we should also point
7 out that the intelligent and effective use by the family
8 doctor of sundry ancillary departments of personnel
9 and otherwise is something we recognize I think in all
10 sorts of connections. Here is something quite un-
11 developed in our society so far. The intelligent use,
12 for example, in this context of mental health of the
13 counselling skills of the well-trained public health
14 nurse who should, in the opinion of most of us, be
15 working in much closer relationship with the family
16 doctor.

17 THE CHAIRMAN: What I want to relate
18 the subject to is the statement that was made that the
19 over-all cost of physicians services in the Province
20 for the forthcoming year was estimated at \$20, million
21 or \$20.5 million, and in this concept that you see as
22 the proper role of the general practitioner would you
23 see a substantial increase in the cost of physicians'
24 services if they are properly utilized in the field in
25 which utilization should be made of them?

26 MR. RANDS: I think we see in the plan
27 we have tried to outline here a great deal more support
28 for the general practitioner and a great many more aids
29 to that extended job. I don't see it as adding an
30 impossible burden if it is accompanied by the kind of ---



1 THE CHAIRMAN: I am not talking about
2 the burden to the individual physician, but whether
3 there would be a substantial increase in the cost of
4 physicians' services to be paid for?

5 DR. A. ROBERTSON: This is by no means
6 a simple question to answer, because it leads us into,
7 among other things, the method of remuneration of
8 physicians.

9 THE CHAIRMAN: On the basis upon which
10 the Act was predicated.

11 DR. A. ROBERTSON: Yes, on that basis
12 I would say that this would not mean a very substantial
13 increase in total cost provided you have re-arrangement
14 of these ancillary facilities I have talked about so
15 they can be intelligently used and that you also have
16 the kinds of continuing education for existing practitioners,
17 which is now starting in this Province, which enables
18 them to perform this function as they should perform
19 it, partly because the effective approach to this
20 kind of care is in the long run a saving approach and
21 is the most economical approach.

22 THE CHAIRMAN: I could stand to be
23 informed by you gentlemen for hours, I am sure.

24 DR. A. ROBERTSON: We are most grateful
25 for your patient hearing at the end of several very
26 long days.

27 THE CHAIRMAN: However, I am going to
28 ask Dr. Baltzan if he has any questions.

29 COMMISSIONER BALTZAN: Gentlemen, I
30 have been very much impressed with your central theme



THE CHAIRMAN: I am not talking about

the basis to the individual physician, the whether

the individual physician is to be paid for

physician's services to be paid for

DR. A. F. FRIEDMAN: It is not for the reason

a simple question to answer, because it involves as well

among other things, the question of responsibility of

physicians.

THE CHAIRMAN: On the basis upon which

the individual physician is to be paid

DR. A. F. FRIEDMAN: It is not on that basis

I would say that this is a very complicated

question to try to answer, but I think you have

to try to answer it, and I think you have

to try to answer it, and I think you have

to try to answer it, and I think you have

which is now coming in to a physician which could be

them to perform this function as they would perform

it. I think you are all efforts to answer to this

kind of case is the long time having approach and

in the most complicated situation

DR. A. F. FRIEDMAN: I am not going to be

influenced by the government, the court, I am sure.

DR. A. F. FRIEDMAN: We are more concerned

how our patients are going to be and of course very

THE CHAIRMAN: However, I am going to

DR. A. F. FRIEDMAN: I am not any physician.

have been very much interested with you, and I



1 that runs through your brief concerning decentralization,
2 regionalization, co-ordination and local autonomy.

3 My question is just simply this: How do your principles
4 of decentralization et cetera fit into the present
5 organization under the Saskatchewan Health Services Act?

6 DR. ACKER: I take it Dr. Baltzan
7 specifically mentions the Health Services Act and not
8 the Medical Care Insurance Act? You refer to the ex-
9 isting Statute?

10 COMMISSIONER BALTZAN: The thing that
11 is on the Statutue books.

12 DR. A. ROBERTSON: The new one or the
13 old one?

14 COMMISSIONER BALTZAN: I didn't know
15 there was more than one. You help me out.

16 DR. ACKER: All right. If I can explain
17 that briefly, the Health Services Act which has been
18 on the Statutue book for about 15 years ---

19 COMMISSIONER BALTZAN: Well, I am talking
20 about the recent one.

21 DR. A. ROBERTSON: The Medical Care
22 Insurance Act.

23 DR. ACKER: The Medical Care Insurance
24 Act, I can only comment to the point of having read
25 the Statute, and without any more knowledge of to what
26 extent the Medical Care Insurance Commission in its
27 current deliberations or in on-going discussions with
28 other interested groups may resolve this point. I do
29 believe the Act probably provides for arrangements
30 whereby various measures of decentralized administration



that runs through your brief concerning decentralization, regionalization, co-ordination and local autonomy. My question is just simply this: How do your principles of decentralization or others fit into the present organization under the Saskatchewan Health Services Act? Specifically mentions the Health Services Act and not the Medical Care Insurance Act? You refer to the existing Statute? COMMISSIONER BALDWIN: The thing that is on the Statute books. DR. A. ROBERTSON: The new one or the old one? COMMISSIONER BALDWIN: I didn't know there was more than one. You help me out. DR. ASKIN: All right. If I can explain that briefly, the Health Services Act which has been on the Statute book for about 15 years --- COMMISSIONER BALDWIN: Well, I am talking about the recent one. DR. A. ROBERTSON: The Medical Care Insurance Act. DR. ASKIN: The Medical Care Insurance Act, I can only comment to the point of having read the Statute, and without any more knowledge of to what extent the Medical Care Insurance Commission in its current deliberations or in on-going discussions with other interested groups may resolve this point. I do believe the Act probably provides for arrangements whereby various measures of decentralized administration



1 can be carried out. To my reading ---

2 COMMISSIONER BALTZAN: That is your
3 reading of it. Can you read me something there that
4 tells you that?

5 DR. ACKER: If I could find this, if
6 you will give me a moment, sir.

7 DR. BRADLEY: Possibly, Mr. Chairman,
8 while Dr. Acker is looking up this point, could I raise
9 another one?

10 THE CHAIRMAN: Yes.

11 DR. BRADLEY: Section 29 of this Brief
12 sets out regionalization as it is applied to health
13 regions, and I would not add anything to section 29,
14 but my colleague, Dr. Sutherland has had experience
15 of working as a practitioner in a health region with a
16 prepaid fee for service medical care plan, apart from
17 his more recent practice in hospitals, and has applied
18 the concept of regionalization to particularly small
19 hospitals, and I think it would be interesting for you
20 to hear from Dr. Sutherland.

21 COMMISSIONER BALTZAN: That, Sir, is
22 quite all right, and we will be glad to hear it, but I
23 don't think that is going to answer the question.

24 DR. BRADLEY: It is totally unrelated,
25 Sir.

26 THE CHAIRMAN: But it is filling the
27 void while Dr. Acker looks up this other point.

28 DR. ACKER: I have it now. Again, I
29 can only give you an immediate interpretation as I have
30 read the Act, Dr. Baltzan, and there may be other impli-



YARD

can be carried out. To my reading ---

COMMISSIONER BARTMAN: That is your

reading of it. Can you read me something there that

tells you that?

You will give me a moment, sir.

While Dr. Acker is looking up this matter, could I make

MR. BARTMAN: Section 19 of this Bill

seem our regional, and it is agreed to section

regions, and I would not and anything to section 19,

but my colleague, Dr. Bartman, has no experience

of working as a generalist in a local region with a

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his more recent practice in hospitals, and has applied

the concept of regionalization to particularly small

hospitals, and I think it would be interesting for you

to hear from Dr. Bartman.

COMMISSIONER BARTMAN: That, sir, is

quite all right, and we will be glad to hear it, but I

don't think that is going to answer the question.

Sir,

THE CHAIRMAN: But is it telling the

read the Act, Dr. Bartman, and there may be other things



1 cations which I did not ---

2 THE CHAIRMAN: I have forgotten the question.

3 DR. BALTZAN: I shall repeat it: How
4 do these principles of decentralization fit into the
5 present organization under this Act?

6 THE CHAIRMAN: I suppose we will all read
7 it for ourselves, and Dr. Acker is not a lawyer.

8 DR. ACKER: That is quite correct.

9 DR. A. ROBERTSON: I think also our
10 feeling would be that the Commission is currently engaged
11 in interpreting this Act.

12 COMMISSIONER: Would you say from your
13 knowledge --- you are not legal people, and I am not one
14 either -- that this concept can be embraced under the
15 terms of the kind of provision...?

16 DR. A. ROBERTSON: Can be embraced.

17 DR. ACKER: I would say this, possibly:
18 I would refer to Section 9 which refers to the powers
19 of the Commission, and this is not denied by any section
20 of the Act.

21 COMMISSIONER BALTZAN: Paragraph 22:
22 "While a great many individual agencies operating in the
23 health field must be concerned with maintaining the quality
24 of health services, government ---- through its public
25 health agency --- must assume a leading responsibility."
26 My question is, a leading responsibility to provide or
27 to instruct or to run the gamut of the service?

28 DR. A. ROBERTSON: I think the whole
29 matter of quality of medical care is so central to our
30 argument that we would like to spend some time replying to



THE CHAIRMAN: I have forgotten the question

DR. BAUMAN: I shall repeat it: How

do these principles of decentralization fit into the

present organization under this Act?

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of the Commission, and this is not denied by any section

of the Act.

DR. ROBERTSON: Paragraph 22:

"While it is true that many individual agencies operating in the

health field must be concerned with maintaining the quality

of health services, nevertheless, --- through the public

health agency -- -- have assumed a leading responsibility."

My question is a leading responsibility to provide or

to instruct or to run the game of the service?

matter of quality of medical care is so central to our

argument that we would like to spend some time verifying to



1 the question, and Dr. Sutherland would be happy to do so.

2 DR. SUTHERLAND: Mr. Chairman, Dr.

3 Baltzan: the sentence relates to quality and it gives
4 government a leading responsibility in the maintenance
5 of quality, and in using the term "quality of health
6 services" I would interpret this as encompassing every
7 phase of health services which can be imagined as being
8 of public interest. This would, I believe, include
9 them all. So, as this sentence is written, it doesn't
10 imply a leading responsibility of the government on
11 anything but quality. This particular field is one
12 we were going to expand in this Brief at one time, so
13 I will recount some of the things we discussed. One
14 of the things which we felt was actually lacking in
15 the health picture at the moment was that responsibility
16 for quality was in very many areas very poorly defined,
jb 2 17 and here you have a distribution between training
18 agencies and professional people, hospitals, government,
19 voluntary agencies, various professional groups other
20 than medical, and quality was the single theme which
21 we felt the government had to accept a responsibility
22 in in all these areas.

23 COMMISSIONER BALTZAN: Is government
24 a better judge of quality, say, than the Association
25 of Nurses?

26 DR. A. ROBERTSON: I wonder if we could
27 clarify our definition of "quality of medical care"?
28 It seems to me the phrase "quality of medical care" is
29 bandied around between physicians and laymen and that
30



the question, and Dr. Sutherland would be happy to do so.

DR. SUTHERLAND: Mr. Chairman, Dr.

Baird, the reference relates to quality and it gives

Government a leading responsibility in the maintenance

of quality, and to using the term "quality of health

services" I would interpret this as not passing every

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agencies and professional people, hospitals, Government,

voluntary agencies, various professional groups other

than medical, and that was the single theme which

we felt the Government had to accept responsibility

a better logic of quality, say, than the Association

of Nurses?

MR. HOBBS: I would like to see if we could

clarify our definition of "quality of medical care."

It seems to me the phrase "quality of medical care" is

handled among various agencies and lawyers and that



1 some of us do not follow the same kind of broad
2 definition that the public health person follows. The
3 definition which we follow is by and large contained
4 in a book called "Medical Care of Tomorrow" by Michael
5 Davis who lists five components of quality of medical
6 care. These five would take me about five minutes
7 to read in full, or I can simply run through them.

8 THE CHAIRMAN: Yes, and tell us where
9 they are.

10 DR. A. ROBERTSON: The first is personnel:
11 well-trained and so forth --- physicians and others;
12 sufficient technical help, and so forth. The second
13 is facilities: buildings, and so forth. The third
14 is organization: service organization and administrative
15 organization and the community organization. The
16 fourth is finance: methods of payment by patients and
17 methods of payment to physicians and other personnel.
18 The fifth is education, which again is divided into
19 two parts: education of the public in the intelligent
20 use of medical services, and education of physicians
21 and allied personnel.

22 Personnel.
23 Facilities.
24 Organization.
25 Finance.
26 Education.

26 We have not thought exclusively about
27 the way in which a given physician or surgeon handles
28 a given individual patient.

29 COMMISSIONER BALTZAN: I will drop it
30 right here, and see if I am right when I think that it



1 some of us do not follow the same kind of broad
2 definition that the public health person follows. The
3 definition which we follow is by and large contained
4 in a book called "Medical Care of Tomorrow" by Michael
5 Davis who lists five components of quality of medical
6 care. These five would take me about five minutes
7 to read in full, or I can simply run through them.
8 THE CHAIRMAN: Yes, and tell us where

9 well-trained and so forth -- physicians and others;
10 sufficient technical help, and so forth. The second
11 is facilities: buildings, and so forth. The third
12 is organization: service organization and administrative
13 organization and the community organization. The
14 fourth is finance: methods of payment by patients and
15 methods of payment to physicians and other personnel.
16 The fifth is education, which again is divided into
17 two parts: education of the public in the intelligent
18 use of medical services, and education of physicians
19 and allied personnel

20 (unintelligible)

21 We have not thought exclusively about
22 the way in which a given physician or surgeon handles
23 a case, but we have thought about the way in which
24 the patient is handled. I am right when I think that is
25 right here, and see if I am right when I think that is



1 may be written something like this: Responsibility for
2 quality may be that of the Government but it does not
3 necessarily mean that Government is the best judge of
4 quality?

5 DR. A. ROBERTSON: It does not mean the
6 Government is exclusively, sir.

7 DR. SUTHERLAND: I would answer that a
8 little differently: That this is an age of Government
9 whereby if it chooses to operate without its technical
10 and professional consultants it would completely give
11 to a few legislators some kind of God given knowledge
12 which no one can have, and no Government can enter into
13 the field of quality without the advice of its advisers
14 and these will usually not be within Government. But
15 a Government does have the responsibility as it co-
16 ordinates or helps to purvey to the people all health
17 services. It has the responsibility to see that agencies
18 of all kinds are contributing to these health services.

19 COMMISSIONER BALTZAN: And organizations
20 and professions, long standing, great experience and
21 devotion.

22 DR. A. ROBERTSON: Yes.

23 DR. SUTHERLAND: Yes.

24 THE CHAIRMAN: Your modesty is
25 appreciated.

26 Dr. Robertson and distinguished gentlemen,
27 this has been a very exhilarating presentation and
28 one from which we will derive a great deal of help.
29 Naturally, we will be referring to the written Brief
30 for any areas of the presentation that were not specifically



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DR. A. ROBERTSON: It does not mean the

DR. SUTHERLAND: I would answer that a little differently. There this is an age of government whereby if it chooses to operate without the technical and professional assistance it would completely lose to a few legislators some kind of God given knowledge which no one can have, and no government can enter into the field of quality without the advice of its advisers and there will result not as with government, but a movement does have the responsibility as to co-ordinates or help to give to the people all health services. It has the responsibility to see that agencies of all kinds are contributing to these health services.

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1 covered in discussion, and I am grateful for myself
2 and on behalf of the other members of the Commission
3 for the time and effort that you put into the prepara-
4 tion of the Brief. I think that is perhaps the best
5 compliment the Commission can pay you --- to have spent
6 the time and brought forward a Brief that does re-
7 present considered views, whether they may be agreed
8 with or not; but, the fact of having accepted seriously
9 the responsibility of putting forward the views is
10 appreciated, and I want to thank you for it.

11 DR. A. ROBERTSON: Thank you very much
12 indeed, sir. I am only sorry you did not have an
13 opportunity of hearing more of my colleagues.

14 THE CHAIRMAN: We will adjourn now until
15 7:30 p.m.

16
17 ---- ADJOURNED UNTIL 7:30 p.m.
18
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the responsibility of putting forward the views is
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MR. A. K. B. F. : Thank you very much.

Indeed, sir. I am only sorry we did not have an
opportunity of hearing more of my colleagues.

THE CHAIRMAN: We will adjourn now until

Next time.



---ON RESUMING AT 7:30 o'clock.

SUBMISSION OF THE FAMILY SERVICE BUREAU
OF REGINA

APPEARANCES:

Miss. Marjorie Bernard

Mrs. D. S. Larter

Mr. W. G. Supynuk

THE CHAIRMAN: We will now hear from
you, Miss Bernard?

MISS BERNARD: Mr. Chairman, and
members of the Royal Commission on Health Services:
we thank you for the opportunity to appear before you
and outline our experience with clients in need of
health services.

Following the terms of your invitation
we examined our case load to find examples of indigent
or medically indigent clients facing problems in obtain-
ing required health services. We examined 391 cases
and to our surprise found only about dozen families
who are not covered with medical care, either because
they qualified for public assistance or are members of
a contributory plan, that is, employer group, Group
Medical Services et cetera. Some of those covered
were in good financial circumstances. We concluded,
therefore, that our clients, regardless of circumstances,
are well cared for.

We are, however, aware of problems that

---ON RESUMING AT 7:30 o'clock.

SUBMISSION OF THE FAMILY SERVICE BUREAU

Mrs. D. S. Jones

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a contributory plan, that is, employer group, group

Medical Services or others. Some of those covered

were in good financial circumstances. We concluded,

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are well cared for.

We are, however, aware of problems that



1 arise on the administrative level. In the Province
2 of Saskatchewan, the Health Bill is included in
3 municipal legislation and social assistance comes under
4 the Welfare Act. While residence qualifications
5 for social aid have been abandoned, health services
6 within a municipality are limited to persons meeting
7 certain residences requirements. While emergency
8 or urgent service is given without delay, we have known
9 the physician to postpone elective surgery until he
10 knew that the account would be paid. The municipality
11 in which a condition first occurs continues to be
12 responsible for treatment of that condition; that is
13 an indigent woman may have bronchitis in a municipality
14 from which she moved several months prior to another
15 attack but the first municipality could be held re-
16 sponsible for the cost of the first.

17 Complaints sometimes come to our
18 attention but these are usually due to misunderstanding.
19 A recipient of public assistance complained that her
20 young son, with a facial disfigurement, was not
21 receiving plastic surgery because the family was unable
22 to pay for it but on investigation we learned that the
23 child was still too young to benefit from plastic
24 surgery and none had been recommended.

25 Now, this covers pretty well what we
26 were asked to do but there is another item that I
27 would like to mention and that is the home care plan
28 for invalid people, long term illness and aged people.
29 We have tried in a small way to meet some of these
30 needs in our agency and through our supervisor's house-



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were asked to do but there is another item, that I

would like to mention and that is the home care plan

for invalid people, long term illness and aged people.

We have tried in a small way to meet some of these

needs in our agency and through our supervisor's bene-



1 keeper services we gave services last year to 21 such
2 persons. We feel, however, it would be most beneficial
3 to many patients with long term illnesses to be cared
4 for in their own homes rather than in an institution.
5 Again, I am sure representations will be made to the
6 Commission referring to our need of more hospital funds and
7 more beds in geriatric centres. We would like to see more
8 care in the home. This would not replace the care
9 in an institution but would be a better plan for our
10 people.

11 Mrs. Larter will give a few illustrations
12 of points I have raised and Mr. Supynuk with any
13 points on administration.

14 MRS. LARTER: Mr. Chairman, members of
15 the Commission, as your invitation to us indicated.

16 Miss Bernard may be accompanied by two social workers
17 each of whom may be prepared to give three case illustrations

18 THE CHAIRMAN: I am sorry if we re-
19 stricted it.

20 MRS. LARTER: This was interpreted
21 literally and I am explaining that I have picked out
22 three. As you can expect from Miss Bernard's brief
23 this will bear out our feeling that our families are
24 not financially in difficulty or in great difficulty in
25 getting either hospital or medical services.

26 THE CHAIRMAN: You see, our concern was
27 that while we were receiving many briefs and submissions
28 from many sources we did appear to be deficient in
29 submissions and in representations from what you might
30 call the consumer groups or those groups who are most



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 2 persons. We feel, however, it would be most beneficial
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 6 Commission referring to our need of more hospital funds and
 7 more beds in existing hospitals. We would like to see more
 8 care in the home. This would not replace the care
 9 in an institution but would be a better plan for our

11 Mrs. Barker will give a few illustrations
 12 of points I have raised and Mr. Guyer will give
 13 points on administration.

15 the Commission, as your invitation to be interested
 16 Mrs. Howard may be accompanied by two social workers
 17 each of whom may be prepared to give three case illustrations
 18 THE CHAIRMAN: I am sorry if we re-

20 Mrs. J. L. T. This was interpreted
 21 incorrectly and I am explaining that I have picked up
 22 correct. As you can expect from Mrs. Howard's brief
 23 this will bear out our feeling that our families are
 24 not adequately in difficulty or in great difficulty in
 25 getting either hospital or medical services.

26 THE CHAIRMAN: You see, our concern was
 27 that while we were receiving many letters and applications
 28 from many sources we did appear to be deficient in
 29 applications and in representations from what you might
 30 call the consumer groups or those groups who are most



1 intimately connected with the consumer groups at a
2 level where need might be most apparent.

3 MISS BERNARD: I believe the three brief
4 descriptions Mrs. Larter has will be of help.

5 MRS. LARTER: We call these families
6 X, Y and Z.

7 Family X is composed of the father, mother
8 and eleven children ranging in age from one month to
9 18 years. Since 1948 this family has been periodically
10 dependent on public assistance. The periods of de-
11 pendence have steadily increased as the family has grown.
12 At the present time they rely completely on social aid.
13 Throughout this period the family has enjoyed the services
14 of an obstetrician, a pediatrician, a dentist and a
15 general practitioner. The family has always had good
16 relationships with its doctors and have consulted them
17 regularly. They have experienced no difficulty in
18 obtaining glasses for the two children who needed them
19 or in obtaining replacement when glasses are broken or
20 corrections need to be changed. This family appreciate
21 the good medical care they have received and have used
22 it judiciously. All the children are normal and healthy
23 and do well in school.

24 Family Y is composed of father, mother
25 and six children ranging in age from 9 to 16 years.
26 The father has always been steadily employed. His net
27 earnings are \$285.99 per month. The mother appears to
28 be somewhat neurotic.

29 In the 13 years this family has been known
30 to our agency, we note from our files that this family



1 intimately connected with the consumer group at a

2 level where need might be most apparent.

3 MISS BARNARD: I believe the three prior

4 descriptions Mrs. Barnard has will be of help.

5 MRS. BARNARD: We call these families

6 Family X is composed of the father, mother

7 and eleven children ranging in age from one month to

8 18 years. Since 1948 this family has been financially

9 dependent on public assistance. The periods of de-

10 pendence have steadily increased as the family has grown.

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13 of an obstetrician, a pediatrician, a dentist and a

14 general practitioner. The family has always had good

15 relationships with the doctors and have consulted them

16 regularly. They have experienced no difficulty in

17 obtaining glasses for the two children who needed them

18 or in obtaining replacement when glasses are broken or

19 the good medical care they have received and have used

20 judicially. All the children are normal and healthy

21 and do well in school.

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23 and six children ranging in age from 9 to 16 years.

24 The father has always been steadily employed. His net

25 is somewhat neurotic.

26 In the 13 years this family has been known

27 to our agency, we note from our files that this family



1 has received an extraordinary amount of medical attention,
2 although neither the parents or the children have any
3 chronic illnesses or congenital disease. For example:
4 one of the little girls has been in hospital 13 times
5 before she was three years old.

6 This family have always demanded medical
7 and surgical specialists. They have apparently given
8 little thought to how the amount of care they demanded
9 would be financed. Often this care appears to have
10 been necessitated more by the mother's neurotic personality
11 than by the actual health needs of the family.

12 This family obtained a coverage under
13 Group Medical Services in 1954. They currently owe
14 our local medical clinic \$665.00 for services rendered
15 before 1954, despite the fact that two grants had been
16 made in 1950 - 1951 by the Army Benevolent Fund for
17 doctors' fee totalling \$710.50.

18 A Writ for \$600. was issued by the clinic
19 in 1956 but the family has made no move to arrange for
20 any form of repayment and the clinic has not pressed
21 further. Despite that they have had no difficulty
22 securing medical attention from this same clinic as
23 often as they deem it necessary.

24 Family Z came to Canada from Europe in
25 1952. They now have four children ranging in age from
26 9 months to 8 years.

27 It was not until 1956 that the father was
28 able to get a steady job which entitled him to join
29 Group Medical Services. The previous year Mr. Z had
30 been very worried over the heavy expense incurred at the



This family have always demanded medical
and surgical specialists. They have apparently given
little thought to how the amount of care they demanded
would be financed. Often this care appears to have
been necessitated more by the patients' autistic personalities
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our local medical clinic \$607.00 for services rendered
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made in 1950 - 1951 by the Army Honorable Fund for
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1 birth of the second child. This was a Caesarean.
2 section and the mother required special duty nurses
3 around the clock for some days. Mr. Z was drawing un-
4 employment insurance and had no way of meeting these
5 expenses. He applied to the City and financial aid
6 was granted to cover the costs of the special nurses.
7 On his own initiative he arranged to repay the obstetrician
8 by doing work the doctor needed done in the home and
9 garden and this worked out to their mutual satisfaction.

10 THE CHAIRMAN: Are these cases typical?

11 MRS. LARTER: They are typical.

12 THE CHAIRMAN: Do you wish to add some-
13 thing Mr. Supynuk?

14 MR. SUPYNUK: No, I have no submission
15 for the Commission. I came this evening to provide
16 answers to questions which may arise about the adminis-
17 tration of medical assistance to indigent persons within
18 the City of Regina.

19 THE CHAIRMAN: How is such assistance
20 provided? I take it, it is provided?

21 MR. SUPYNUK: We have an arrangement
22 with Medical Services Incorporated whereby a client
23 requiring medical assistance goes to the physician
24 of his own choice. The physician forwards his account
25 for processing to the M.S.I. local office; the account
26 is then forwarded in a list to our department for
27 verification as to whether or not this person is in
28 receipt of either social assistance or medical assistance
29 from the City of Regina. The list then is returned to
30 the M.S.I. office and they in turn reimburse the physicians



birth of the second child. This was a Cesarean
section and the mother required special duty nurses
around the clock for some days. Mr. A was drawing an-

expenses. He applied to the City and Hospital and
was granted to cover the costs of the special nurses.
On his own initiative he arranged to repay the obstetric
by doing work the doctor needed done in the home and
garden and this worked out to their mutual satisfaction.

THE CHAIRMAN: Do you wish to add now -
THE CHAIRMAN: They are typical.

Mr. Murphy: No, I have no objection
for the Commission. I am not overjoyed to provide
any more positions which may arise out of the hospital
situation of medical assistance to pregnant persons with
the City of Regina.

THE CHAIRMAN: How is your assistance
with Medical Services Incorporated whereby a clinic
requiring medical assistance goes to the physician
of his own choice. The physician forwards his account
for processing to the M.H.I. local office; the account
is then forwarded as a list to our department for
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from the City of Regina. The list then is returned to



1 85% of the schedule established by the provincial
2 College of Physicians and Surgeons. The local office
3 of M.S.I. then charges the City of Regina an additional
4 charge amounting to 5% of the amount of allowed claims.

5 THE CHAIRMAN: This 5% represents what?

6 MR. SUPYNUK: 5% of the amount that is
7 paid.

8 THE CHAIRMAN: What is it for?

9 MR. SUPYNUK: It is their administration
10 charge. Each client is given an identification card
11 which authorizes services which can be given in an
12 office or home visit by a physician. The additional ser-
13 vices over and above these must get clearance by a
14 medical referee committee established by the Medical
15 Services Incorporated for such things as consultation
16 of specialists, elective surgery, major diagnostic
17 investigations, physiotherapy. Now, these are
18 services that were provided by physicians. In the
19 City of Regina we have the limited dental program for
20 children. We have a preventive service which consists
21 of authorizing of the type of fluoridation treatment
22 that can be provided in the dentist office. We only
23 issue fluoride tablets to mothers of indigent children
24 upon their request. We provide no restorative
25 services such as fillings for children. We provide
26 extractions for the relief of pain only. There is
27 a very limited denture program granted to a recipient
28 upon a triple recommendation of his physician, his dentist
29 and a member of our department. With dentures the
30 patient is expected to pay up to 25% of the actual cost



85% of the schedule established by the provincial

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of M.S.I. then charges the City of Regina an additional

charge amounting to 2% of the amount of allowed claims.

THE CHAIRMAN: This is representative of

MR. GUYMOR: 2% of the amount that is

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upon a triple recommendation of the physician, the dentist

and a member of our department. With dentures the



1 of the dentures which, I must add, is provided at cost
2 by the dentist. With regard to drugs and prescriptions
3 the client can have the prescription filled by his local
4 pharmacist. Recently City council has adopted the
5 policy that the client be required to pay a 10% deterrent
6 fee but the deterrent fees on dentures and the deterrent
7 fee on prescriptions can be waived under necessity
8 circumstances. These briefly are the medical services
9 for indigents in the City of Regina. I must add
b/ jb 10 one more important detail. The cost of providing
11 medical services to indigents is borne one hundred
12 percent by the Municipality of the City of Regina.
13 There is no cost-sharing or reimbursement from either
14 Provincial or Federal funds.

15 THE CHAIRMAN: How do you determine
16 whether a person qualifies as an indigent?

17 MR. SUPYNUK: Most of the persons who
18 receive indigent medical services are those clients
19 who have established eligibility for social assistance,
20 and that financial program is under a needs test.
21 For persons who apply for medical assistance, who are
22 not in receipt of social aid, they are required to
23 submit to a needs test. The needs test for the two
24 programs is very similar. We just use the same
25 general needs test to apply to both. It is just a
26 question of differences of computation and so on.

27 THE CHAIRMAN: Have you a standard
28 to go by, or is it a matter of judgment in the
29 individual case?

30 MR. SUPYNUK: No, under the needs test



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MR. SUPYNUK: No, under the needs test



1 there is a standard under which we can, we try to
2 measure need according to a defined criterion. In
3 our Province this would be schedules of allowances,
4 or assessments of need, and you contrast this with the
5 person's actual income, and if a deficit results, then
6 the person clearly establishes eligibility. If a
7 surplus results, but the surplus is not adequate to
8 provide for in the cases of medically indigent persons,
9 for except the medical expenses, then of course, he is
10 also eligible. Persons for medical purposes who are
11 not eligible are those persons who it is clear that
12 they have insufficient funds, not only to provide food,
13 clothing and shelter, but for essential medical care.

14 THE CHAIRMAN: Perhaps I will put this
15 as a general question. Are you in a position to say,
16 one way or the other, whether in the circumstances offered
17 today there are any people in Regina going without
18 necessary medical attention for any reason?

19 MR. SUPYNUK: I cannot speak from direct
20 experience or knowledge of actual cases. I can just
21 speculate, Mr. Chairman. I think actually the group
22 who are probably the ones who are suffering most
23 hardship are those persons who are in the low income
24 groups, who are not able to qualify for a form of public
25 assistance. These would be fully-employed people,
26 probably with large families and low incomes and
27 financial pressures on these families are very great.

28 THE CHAIRMAN: Do you know of any
29 individual cases in that group who have suffered?
30 I mean to say, who have been deprived of medical service,



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THE CHAIRMAN: Do you know of any

individual cases in that group who have suffered

I mean to say, who have been deprived of medical service.



1 either through being refused by a doctor, or not going
2 to a doctor because they have no money?

3 MR. SUPYNUK: Mr. Chairman, I honestly
4 say I cannot quote from actual experience, and this is
5 one of the disadvantages of being in an administrative
6 position rather than working directly with clients.

7 THE CHAIRMAN: Yes, but you would get
8 information from your case workers?

9 MR. SUPYNUK: Yes, but as I say, I
10 cannot in all honesty quote an actual case. I think if
11 I did some research, that there is excellent possibilities
12 that I could come up with a good case example for you.

13 THE CHAIRMAN: Mrs. Larter, in your
14 case?

15 MRS. LARTER: Before we moved to Regina,
16 I was a social worker in the Moose Jaw Hospital for
17 four years, and had an opportunity not only to see how
18 we used our hospital services plan, which worried me,
19 but also to see how doctors were able to work with
20 indigent people because very often we would have completely
21 indigent people admitted from emergency, and I can think
22 of no case whatsoever where service was either refused
23 or begrudged. Now, this is only one small City in one
24 small Province.

25 THE CHAIRMAN: In a four year period?

26 MRS. LARTER: In a four year period,
27 and in many cases it was quite evident the doctor was
28 never going to be paid from some of these transient
29 indigent men, and I have seen some of the most
30 painstaking service given to some of these, I quote



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MR. SUTYUK: Yes, but as I say, I

cannot in all honesty quote on actual cases. I think I did some research, that there is excellent possibility that I could come up with a good case example for you.

THE CHAIRMAN: What, later, in your

cases?

MRS. LARTER: Before we moved to Berlin,

I was a social worker in the Moscow and Leningrad

four years, and had an opportunity not only to see how

we used our hospital services and, which worked me,

but also to see how doctors were able to work with

indigent people because very often we would have complete

forget people admitted from emergency, and I can think

of no case whatever where service was either refused

or delayed. Now, this is only one small city in one

small province.

THE CHAIRMAN: In a four year period?

MRS. LARTER: In a four year period.

and in many cases it was quite evident the doctor was

never going to be paid from some of these transient

indigent men, and I have seen some of the most

painstaking service given to some of these, I quote



1 "old bums". I remember one particular case, where this
2 old gentleman had pellegrini. This is very difficult
3 to diagnose because this is a rather archaic disease,
4 and most of the young doctors hadn't seen this, but
5 this particular gentleman was the object of study and
6 consultation and care, and he stayed in the hospital
7 approximately 8 months, and no one ever collected any-
8 thing, the hospital or the doctors, for his care.

9 THE CHAIRMAN: He had no hospitalization
10 card either?

11 MRS. LARTER: No.

12 THE CHAIRMAN: In that case it is the
13 hospital subsidized his hospital care.

14 MR. LARTER: And the doctors who
15 subsidized his medical treatment.

16 MR. SUPYNUK: I think the Commission
17 would be interested to know this, that in our Province
18 here, and I just want to re-emphasize something that came
19 out in Miss Bernard's submission. From an administrative
20 point of view, to all intents and purposes, we would have
21 to split a client down the middle, because if he requires
22 financial assistance there are no residential qualifications.
23 However, for medical assistance we have to go through a
24 different piece of legislation and use its sections to
25 determine the responsibilities. I am speaking of re-
26 sponsibility for payment, and I do know that there is some
27 disagreement between municipalities as to who is to end
28 up paying the bill.

29 THE CHAIRMAN: It is a question of
30 residence, isn't it?



"old drama". I remember one particular case, where this
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THE CHAIRMAN: He had no hospitalization

MRS. JARVIS: No.

THE CHAIRMAN: In that case it is the

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MR. JARVIS: And the doctors who

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MR. BRYAN: I think the Commission

would be interested to know this, that in our Province

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out to Mrs. Bernard's submission. From an administrative

point of view, to all intents and purposes, we would have

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different phase of legislation and use its sections to

determine the responsibilities. I am speaking of re-

sponsibility for payment, and I do know that there is some

disagreement between municipalities as to who is to end

up paying the bill.

THE CHAIRMAN: It is a question of



1 MR. SUPYNUK: Yes, that is correct. To
2 put it simply, the municipality which is responsible is
3 the municipality in which the indigent person last
4 lived for 30 days, but this has recently been complicated
5 by an interpretation of the Attorney-General's Department,
6 and this interpretation was incorporated in Miss Bernard's
7 example, where if a person had an illness of which the
8 onset occurred in one municipality, this municipality
9 is legally responsible for the treatment of that
10 particular ailment, even although the person has moved
11 somewhere else.

12 THE CHAIRMAN: Is there anything further
13 you wish to add, Miss Bernard?

14 MISS BERNARD: Just in answer to your
15 question about people who didn't get medical services.
16 I had a woman tell me today that her husband had not
17 permitted her to call the doctor when her child had
18 influenza. . . . Actually the child recovered. However,
19 in spite of her husband saying he was out of work
20 and couldn't afford a doctor, he drives a car and goes
21 fishing through the ice and so on. So I think in most
22 cases there is actual economic need. The services are
23 available, and they have only to make the application.

24 THE CHAIRMAN: Thank you very much,
25 Miss Bernard and Mrs. Larter and Mr. Supynuk. It was
26 very gracious of you to respond to our invitation
27 because we wanted to hear the story from those who were
28 working at the grass roots level.

29 The Saskatchewan Physical Therapists
30 Association.



the municipality in which the indigent person last
lived for 30 days, but this has recently been complicated
by an interpretation of the Attorney-General's Department

as legally responsible for the treatment of that
particular ailment, even though the person has moved
elsewhere since.

THE CHAIRMAN: Is there anything further
you wish to add, Miss Barnard?

MISS BARNARD: I am in answer to your
question about people who do not get medical services.
I had a woman tell me today that her husband had
retired for to sell the doctor when he could not
improve. Actually he could not recover. However,

in order to get better service he was out of work
and without a doctor, he drives a car and goes
flapping through the ice and so on. So I think in most
cases where in school services are needed. The services are
available and they have only to make the application.

THE CHAIRMAN: Thank you very much.
Miss Barnard and Mrs. Jarrett and Mr. Gwynne. It was

very pleasant of you to respond to our invitation
because we wanted to hear the story from those who were
working at the grass roots level.



1 ---EXHIBIT No. 93: Submission of the Saskatchewan
2 Physical Therapists Association.

3 -----

4 SUBMISSION OF THE SASKATCHEWAN PHYSICAL
5 THERAPISTS ASSOCIATION

6
7 APPEARANCES:

8 Mr. Jerry Smithwick

9 Miss Doreen Moore

10 Dr. T. E. Hunt

11 -----

12 MR. SMITHWICK: Mr. Chairman and
13 members of the Commission, I am Jerry Smithwick, President
14 of the Saskatchewan Physical Therapists Association,
15 and I would like to introduce Miss Doreen Moore, a
16 member of the Council of the Saskatchewan Physical
17 Therapists Association, and Dr. T. E. Hunt, Director
18 of Rehabilitation at the University Hospital. He is
19 also Medical Adviser to our Association, and acts on
20 the Examination Board at the University on behalf of our
21 Association.

22 THE CHAIRMAN: I am quite pleased to see
23 this delegation. I don't know Miss Moore, but Dr. Hunt
24 and yourself.

25 MR. SMITHWICK: I think probably you
26 would appreciate it if we would --- the main first
27 page of our Brief deals with the practice of physio-
28 therapy, and you have the Brief, so I thought it would
29 be better if we were to first skip over to the re-
30 commendations, and deal with those.



Information of the Saskatchewan

Dr. T. M. Hunt

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be better if we were to first ship over to the no-

commentaries, and deal with those.



1 THE CHAIRMAN: If you will.

2 MR. SMITHWICK: The Saskatchewan

3 Physical Therapists Association recommends that Physio-
4 therapy be included as an essential part of health care
5 for Canadians, on the grounds that:-

6 a) Physiotherapy in any hospital materially
7 shortens recovery time, thus making more
8 effective use of hospital facilities;

9 b) Physiotherapy raises the level of functional
10 recovery;

11 c) Physiotherapy given either in out-patient
12 departments or in private practice will
13 facilitate optimal use of hospital beds.

14 d) Physiotherapy in Primary and Secondary Schools
15 is valuable for the prevention and treatment
16 of postural error, deformity and early re-
17 spiratory malfunction.

18 e) Physiotherapy when used in postnatal and
19 infant clinics aids the restoration of posture
20 and function of the mother and the early
21 treatment of congenital deformity.

22 That, as many patients have not reached
23 their maximum recovery before discharge from hospital,
24 continuation of treatment should be facilitated through
25 private and out-patient practice, physical restoration
26 centres, or domiciliary services where available.

27 That the standards required by the
28 Saskatchewan Physical Therapists Association in con-
29 junction with the Examiner's Board of the University of
30 Saskatchewan be maintained, as stated in the Saskatchewan

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junction with the Examiner's Board of the University of
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1 Physical Therapists' Act.

2 That a three year course in physiotherapy
3 be considered the minimum standard, with as many re-
4 cognized credit classes as possible during this period
5 to allow therapists to continue later to a degree course.

6 THE CHAIRMAN: What is the minimum now?

7 MR. SMITHWICK: Well, in Canada they
8 are three year courses, but Manitoba this year has a
9 two year course just starting off. Alberta did the
10 same, but then they found they wanted to raise it up
11 to three years.

12 That the actuarial study of salaries for
13 physiotherapists as compiled and recommended by the
14 Canadian Physiotherapy Association be implemented.

15 The next two here we would like to expound
16 on a little further after, and also number 16, if we
17 could please.

18 12. That a regular scheme of post-graduate
19 courses in physiotherapy be established by the allocation
20 of bursaries to extend the educational field for
21 physiotherapists, this to include facilities for teacher
22 training and research.

23 I might say there is very little opportunity
24 for post-graduate work in Canada in our particular field.

25 13. That Dominion Provincial Grants be made
26 available to all practising physiotherapists as well as
27 those in government employ.

28 14. That facilities for the training of male
29 therapists be improved.

30 And I would just like to add a little bit



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those in government employ.

That facilities for the training of physio-

therapists be improved.

And I would just like to add a little bit



1 here on my own, that we feel that this money is coming
2 from all the public, and that these bursaries to do
3 initial study in physiotherapy or post-graduate work,
4 that all physiotherapists, whether working for the
5 Government or private hospitals, or even though those
6 in private practice, should have the opportunity to make
7 use of these bursaries.

8 THE CHAIRMAN: Are these grants now
9 limited only to those in Government employment?

10 MR. SMITHWICK: As far as I know that
11 is the practice in this Province.

12 DR. HUNT: I could speak on that later,
13 sir.

14 MR. SMITHWICK: 15. That consideration
15 be given to the training of blind and partially sighted
16 persons in physiotherapy in Canada.

17 16. That no dilution of standards be permitted
18 either by the institution of shorter courses or the
19 training of semi-professional personnel, e.g. aides or
20 assistants.

21 17. That suitable incentives be offered to
22 encourage physiotherapists to practice in rural areas
23 where such services are presently minimal or non-
24 existent.

25 THE CHAIRMAN: You wanted to amplify
26 both 12 and 13 and 16?

27 MR. SMITHWICK: Yes, well, anything
28 you wish to ask us as far as that goes, but we are
29 particularly interested in those three ourselves.

30 THE CHAIRMAN: Dr. Hunt, you were going



1 here on my own, that we feel that this money is coming
 2 from all the public, and that these hospitals to do
 3 initial study in psychotherapy or post-graduate work,
 4 that all psychotherapists, whether working for the
 5 Government or private hospitals, or even though those
 6 in private practice, should have the opportunity to make
 7 use of these hospitals.

8 THE CHAIRMAN: Are there any other

9 MR. LINDWICK: As far as I know that

10 in the practice in this country.

11 sir.

12 be given to the training of films and possibly other

13 persons in psychotherapy in Canada.

14 That no division of standards be permitted

15 either by the institution or another course on the

16 training of semi-qualified persons, e.g. those on

17 and so on.

18 That suitable individuals be referred to

19 encourage psychotherapists to practice in rural areas.

20 existing.

21 THE CHAIRMAN: You wanted to suggest

22 both 12 and 13 and 14.

23 MR. LINDWICK: Yes, well, anything

24 you wish to ask us as far as that goes, but we are

25 particularly interested in these three ourselves.

26 THE CHAIRMAN: Dr. Lindwick, you were going



1 to deal with number 13?

2 DR. HUNT: Yes sir, both as a person
3 who encourages physiotherapists and also as one who
4 hires physiotherapists. Particularly in the Prairies
5 here, where we are fairly spread out, or removed from
6 major medical centers. Even though we have our own
7 university center, we do not have the opportunity for
8 our therapists to take post-graduate study in a special
9 field. An example came up recently in the special
10 field of training people to use braces for the upper
11 extremities. These are quite complicated. They are
12 being developed by research in the United States con-
13 tinuously. Or another example is the use of the
14 artificial hand, or artificial hooks. There are only
15 certain places in the United States where adequate
16 training at post-graduate level can be given in these
17 fields.

18 We would like to be able to send therapists,
19 as well as doctors on courses of this nature. Some-
20 times they last a week, sometimes a matter of several
21 months.

22 Bursaries are available through share
23 and non-share grants, but there is a stipulation that
24 the person must not work in the hospital, otherwise the
25 hospital is supposed to pay for it, and as I pointed
26 out yesterday, the hospital budgets are extremely limited,
27 so the therapists who work in the hospitals, where we
28 feel rehabilitation should be concentrated, cannot get
29 the necessary post-graduate training, because of
30 limitations in the regulations dealing with bursaries or



DR. HUNT: Yes sir, both as a person

Particularly in the physical therapy field. An example came recently to the attention of training people to use braces for the upper extremities. These are quite complicated. They are being developed by research in the United States and abroad. On another example is the use of the artificial hand, or artificial necks. These are only certain places in the United States where adequate training at post-graduate level can be given. In these

we would like to be able to send them to as well as doctors or nurses of this nature. Some- times they last a week, sometimes a matter of several

and non-graduate groups, but there is a stipulation that the person must not work in the hospital, otherwise the hospital is supposed to pay for it, and as I pointed

as the therapists who work in the hospitals, where we feel rehabilitation should be concentrated, cannot get the necessary post-graduate training, because of



1 scholarships for post-graduate study. We feel there-
2 fore, taking both items 12 and 13, that there should be
3 throughout Canada much more liberal local use, according
4 to local need. Now, in some hospitals, particularly
5 in the major cities in the East, rehabilitation work
6 is not done in the hospital. It is done in a re-
7 habilitation center. We have centers here, but we
8 feel that the work should be in the hospital more, or
9 perhaps in private practice, and these people should have
10 an opportunity of doing this kind of work too, as well
11 as those who work in Government rehabilitation centers,
12 or voluntary centers.

13 THE CHAIRMAN: Is there a trend, in
14 terms of physical disability, requiring use of more
15 physiotherapy, for instance either from industrial
16 accidents or from road accidents?

17 DR. HUNT: Oh, certainly sir. This
18 is one of the most numerous, most used advances since
19 the last World War that we have had in medicine actually,
20 in terms of numbers, not as dramatic as cardiac
21 surgery for example, but even in cardiac surgery our
22 physiotherapists are there helping the patients in their
23 recovery stage. There is certainly an increasing demand,
24 and they must know special techniques which they are not
25 taught as under-graduates.

jb 1 26 THE CHAIRMAN: As part of the medical
27 team you think that the therapist must be brought
28 along with the rest of the team?

29 DR. HUNT: Certainly. In some fields
30 we can give local on the job training. I think this has



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THE CHAIRMAN: Is there a third, in
 terms of physical disability, requiring use of more
 physiotherapy, for instance, than in the hospital?
 activities of the kind I mentioned?
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 recovery stage. There is certainly an increasing demand
 and they must know special techniques which they are not
 taught in their education.

THE CHAIRMAN: As far as the medical
 team you think that the specialists must be brought
 along with the rest of the team.
 IR. WINT: Generally, in some field
 we can give local in the job situation. I think this has



1 been true of our cardiac work, but we haven't the
2 experience to give them training in things such as the
3 use of special devices to help the person who has a
4 paralyzed upper extremity.

5 THE CHAIRMAN: Where are the personnel
6 coming from? Say we have the rehabilitation centres
7 elsewhere: where are the trained people for those
8 centres coming from if you have no post-graduate facilities
9 in Canada?

10 DR. HUNT: I don't quite get your meaning,
11 sir.

12 THE CHAIRMAN: Well, we have these re-
13 habilitation centres: they must be staffed by com-
14 petent people. Where are they being trained?

15 DR. HUNT: My point there was that these
16 people because they are in a centre and not in a hospital,
17 the regulation applies to them. They are not limited,
18 because they work in a hospital.

19 MR. SMITHWICK: We feel if there is a
20 therapist who is really interested in a particular field
21 and would like to go away and get post-graduate training,
22 it is difficult for someone working...

23 THE CHAIRMAN: For instance, in your
24 own organization, could you go, or one of your employees?

25 MR. SMITHWICK: Well, I haven't had the
26 opportunity. However, if there is a particular field
27 I would be interested in, I would like to go, but I would
28 need help.

29 THE CHAIRMAN: But do you qualify for
30 a grant that is presently available?



1 MR. SMITHWICK: As far as I know, I
2 don't; I don't think I would have a chance. But, the
3 thing is, if I was interested and could go away and have
4 a course with the agreement that when I came back I
5 gave lectures to the others in the district, to pass on
6 the training to them, I think it would be of tremendous
7 help to all the physiotherapists and you have got to do
8 these things with the people interested in doing them.

9 THE CHAIRMAN: Personally you wouldn't
10 mind the condition being attached to the grant?

11 MR. SMITHWICK: Not at all.

12 THE CHAIRMAN: Is that a personal view,
13 or do you think it would apply generally?

14 MR. SMITHWICK: I think it would apply
15 generally.

16 DR. HUNT: I don't think this is the
17 same type of bursary you were talking about this after-
18 noon, Mr. Chairman. This is post-graduate; it is
19 not under-graduate, which means more years involved.
20 We have found that with physiotherapists, they don't
21 take advantage of the under-graduate training because
22 it means so many years involved in one locality.

23 THE CHAIRMAN: If we move into the
24 post-graduate field...?

25 DR. HUNT: It is a shorter term.

26 THE CHAIRMAN: The condition is not
27 an impediment.

28 DR. HUNT: The only time it is not
29 available --- this comes up in the last phrase of
30 item 12: We have no bursaries available through federal



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don't; I don't think I would have a chance. But, the thing is, if I was interested and could go away and have a course with the agreement that when I came back I gave lectures to the others in the district, to pass on the training to them, I think it would be of tremendous help to all the physiologists and you have got to do these things with the people interested in doing them.

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Item 12: We have no personnel available through Federal



1 funds to take a worthwhile therapist to send away for
2 training to come back and be a teacher in a proposed
3 school if we were developing one. The only bursary
4 I know that is available for this is given through the
5 Arthritis Society.

6 COMMISSIONER BALTZAN: Mr. Smithwick,
7 you said you were not qualified. I want to qualify that.

8 MR. SMITHWICK: No, I didn't say that.
9 I am not, as far as I know, qualified according to the
10 conditions set out by the Government to get this bursary.
11 I don't mean my qualifications as a therapist.

12 COMMISSIONER BALTZAN: You are a graduate
13 of the University of Saskatchewan, and I see there are
14 no male therapists ever been trained in Canada, so
15 you had it elsewhere?

16 MR. SMITHWICK: In the United States,
17 yes.

18 COMMISSIONER BALTZAN: How long is that?

19 MR. SMITHWICK: It is a four year course
20 in which you can get your Bachelor of Science or Bachelor
21 of Arts. If you get it here, you can go to the United
22 States and they will give you credit for two of the
23 years.

24 COMMISSIONER BALTZAN: Did you get
25 credit for your work in Saskatchewan?

26 MR. SMITHWICK: Yes.

27 COMMISSIONER BALTZAN: And you were
28 able to get your qualifying degree?

29 MR. SMITHWICK: Yes.

30 COMMISSIONER BALTZAN: Well, I still



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28 COMMISSIONER BALDWIN: And you were
29 able to get your qualifying degree?
30 MR. SMITHWICK: Yes.
31 COMMISSIONER BALDWIN: Well, I still



1 think you are qualified.

2 MR. SMITHWICK: I didn't mean it that
3 way.

4 COMMISSIONER BALTZAN: I am very much
5 interested in number 23 on page 4. It is a revelation,
6 I must say: the training and employment of blind and
7 partially sighted persons has proved not only a desirable
8 form of rehabilitation in itself but also an effective
9 means of helping to overcome the shortage of personnel.
10 I have this question: Can such handicapped people
11 as you mention in paragraph 3 take the full three years
12 course?

13 MISS MOORE: Mr. Chairman, I have had
14 the opportunity of working with partially sighted and
15 blind personnel, and this was placed in our brief because
16 we have in our Association two members who come under
17 this heading of partially sighted. The therapists
18 I have worked with have been very adequate and have been
19 able to manage every technique. A partially sighted
20 person -- there are certain techniques which they do
21 not do and, of course, with a totally blind person.
22 However, various methods have been developed so these
23 people can work, can do training and, indeed, there is
24 a very big school in London. We feel these people
25 could be employed. I would have no hesitation in
26 having this type of person on my staff and, as we say
27 too, it is a desirable form of rehabilitation.

28 COMMISSIONER BALTZAN: It works both
29 ways.

30 MISS MOORE: Yes. There is nowhere



MR. SMITHWICK: I didn't hear it first

way.

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I must say: the training and employment of blind and
partially sighted persons has proved not only a desirable
form of rehabilitation in itself but also an effective
means of helping to overcome the handicap of handicap.

I have this question. Can we train handicapped people
as you mention in paragraph 3 that the full time year

MISS MOORE: Mr. Chairman, I have had

the opportunity of working with partially sighted and
blind personnel, and only one thing is clear to me and that is
we have in our association two classes of people. The one class
is the reading of partially sighted. The second class
I have worked with have been very adaptive and have been
able to make very effective use of their eyes. I have
person -- there are certain techniques which they do
not do and, of course, with a totally blind person.
However, various methods have been developed so that
people can work, can be trained and, indeed, there is
a very big school in London. We feel these people
could be employed. I would have no hesitation in
having this type of person on my staff and, as we say
too, it is a desirable form of rehabilitation.

MISS MOORE: Yes, there are numbers



1 at present in Canada where this person could train.

2 We are trying to do something about this. They would
3 have to go to England, as far as I know.

4 COMMISSIONER BALTZAN: It would depend
5 upon the degree of their sight impairment whether or
6 not they could be self-employed or whether they would
7 have to work in the hospital?

8 MISS MOORE: I would think they would
9 be best suited to a large institution where there would
10 be more specific work for them today, rather than work
11 for themselves; but we would have no difficulty in
12 placing such a person.

13 THE CHAIRMAN: Is there another aspect
14 of the work that you have any observations to make on,
15 Miss Moore?

16 MISS MOORE: Could I bring your
17 attention back to number 16?

18 THE CHAIRMAN: Yes.

19 MISS MOORE: You may wonder why, when I
20 know in various other briefs and in our own we say there
21 is a serious shortage of personnel: this is so, but
22 we don't believe it could be overcome by partial training
23 in any form, either by in-service training of aides or
24 assistants. I have assistants in my own departments
25 whom I would not be without. They are very valuable
26 persons. However, because they are not adequately
27 trained I cannot give them any responsibility. We
28 feel if we start this in-service training or partial
29 training that a situation may develop where the people
30 will go to areas not adequately staffed and be employed



at present in Canada where this person could train.
We are trying to do something about this. They would
have to go to England, as far as I know.

COMMISSIONER BARTON: It would depend
upon the degree of their sight impairment whether or
not they could be self-employed or whether they would

MISS MOORE: I would think they would
be best suited to a large institution where there would
be more specific work for them today, rather than work
for themselves; but we would have no difficulty in
placing such a person.

THE CHAIRMAN: Is there another aspect
of the work that you have any observations to make on.

MISS MOORE:

MISS MOORE: Could I bring your

attention back to number 10?

MISS MOORE: You may wonder why, when I

know in various other parts and in our own we say there
is a lack of personnel; this is so, but

we don't believe it could be overcome by partial training

in any form, either by in-service training or aides or

assistants. I have assistants in my own department

whom I would not be without. They are very valuable

persons. However, because they are not adequately

trained I cannot give them any responsibility. We

feel if we want this in-service training or partial

training that a situation may develop where the people

will go to areas not adequately staffed and be employed



1 as trained personnel and not properly supervised. This
2 brings about a situation which I am sure would not
3 want to be encouraged by the doctors or government or
4 any other institution.

5 DR. HUNT: This is a matter, Mr.
6 Chairman, which has been given a lot of considered
7 thought by the Directors of the schools of physiotherapy
8 across Canada, of which I am a member. These are
9 medical persons as well as the Directors of the Training
10 Committee of the Canadian Physiotherapy Association.
11 The reason we bring this up is because there is a lot
12 of talk in a number of circles that this may be an
13 answer to the shortage, the same way as Miss Girard
14 knows with the nursing aid and the nursing assistant,
15 and that special short courses, as were started for the
16 nursing aid and the nursing assistant might relieve
17 the situation. It would only relieve it in big
18 hospitals where they could perform certain manual
19 tasks. There is really nothing comparable in terms
20 of doing things for departments with physiotherapy as
21 there is with nursing, so much of the work depends on
22 personal judgment. There are a few things such
23 as bringing a patient to and from a department, such
24 as making beds, such as cleaning out a Hopper tank or
25 a whirlpool tank, but you don't need a course of a year
26 to teach people to do this. They can learn it on the
27 job.

28 COMMISSIONER GIRARD: Dr. Hunt, you
29 know of the project that the V.O.N. is carrying on in
30 home care and rehabilitation, and I understand home care



...at a situation which I am sure would not
 be encouraged by the doctor or government in
 any other institution.

DR. HUNT: That is a matter, Mr.

Chairman, which has been given a lot of consideration
 thought by the Directors of the schools of psychiatry
 across Canada, of which I am a member. These are

medical persons as well as the Directors of the Training
 Committee of the Canadian Psychiatric Association.
 The reason we bring this up is because there is a lot

of talk in a number of circles that this may be an
 answer to the shortage, the same way as what I said
 about with the nursing and the nursing shortage,

and that special short courses, as were started for the
 nursing aid and the nursing assistant might relieve
 the situation. It would only relieve it in big

departments where they could perform certain amount
 of duties. There is really nothing comparable in terms
 of duties except for departments which have a very

there is with nursing, so much of the work depends on
 personal judgment. There are a few things which
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as making beds, such as cleaning out a hospital, or
 a hospital task, but you don't need a course of a year
 to teach people to do this. They can learn it on the

job.

COMMISSIONER CLARK: Mr. Hunt, you

know of the project that the M.O.M. is carrying on in
 home care and rehabilitation, and I understand home care



1 is one of your pet projects also, and that you have your
2 own personal ideas on home care, and where it should
3 be based --- community based or hospital based: would
4 you like to elaborate on that?

5 DR. HUNT: I don't know whether this
6 particular brief is the place to do that, or the next
7 one.

8 COMMISSIONER GIRARD: It has come up
9 in three different briefs and you have not had a chance
10 yet.

11 THE CHAIRMAN: Were you going to deal
12 with it subsequently?

13 DR. HUNT: I was going to say a word on
14 it if asked the question in the next submission.

15 THE CHAIRMAN: Well, we will see the
16 question is put to you the next time.

17 Thank you very much Dr. Hunt, Mr.
18 Smithwick and Miss Moore. This brief, your submissions
19 and the information you have given us will be of
20 value in the over-all picture as we come to consider
21 the matter of these services. Thank you very much.

22 MR. SMITHWICK: We wish to thank you,
23 Mr. Chairman, for the opportunity.

24

25

26

27

28

29

30



is one of your pet projects also, and that you have your own personal ideas on home care, and where it should

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THE CHAIRMAN: Well, we will see how the question is put to you the next time. Thank you very much Mr. Hunt, Mr.

Garrison and Mrs. Moore. This belief, your submission and the information you have given us will be of value in the overall picture as we come to consider the matter of these services. Thank you very much. MR. GARRISON: We wish to thank you, Mr. Chairman, for the opportunity.



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TORONTO, ONTARIO

Buckwold

4558

1 SUBMISSION OF CO-ORDINATING COUNCIL ON
2 REHABILITATION

3 APPEARANCES:

4 Dr. A. E. Buckwold

5 Dr. G. A. Roeher

6 Dr. T. E. Hunt

7 Mr. R. Talbot

8 Dr. B. Bachynski

9 Mr. W. Bates

10

11 ---EXHIBIT No. 94: Submission of the Co-ordinating
12 Council on Rehabilitation

13

14

15 DR. BUCKWOLD: Mr. Chairman, before
16 proceeding with the Brief may I thank you and your

17 Commission for the indulgence in acceptance of this

18 presentation, copies of which were only recently made

19 available to you. I should point out there are two

20 sections to this Brief: the general summary which you

21 have at hand, and a detailed plan for a positive

22 program in Saskatchewan. This detailed plan has been

23 submitted to your Research Department.

24 The people here, as you know, are

25 representative of many different disciplines indicating

26 that there is a growing feeling amongst all groups

27 dealing with health matters that priority number one

28 in the matter of unmet needs, health needs, is that of

29 rehabilitation. The medical profession, the educational

30 authorities, voluntary agencies, government departments,

recognizing this trend towards total medical care and



Dr. A. E. Jackson

Dr. T. E. Hunt

Mr. E. T. Tipton

Mr. W. H. Baker

---EXHIBIT to the: Department of the Interior
Bureau of Reclamation

Dr. E. E. Jackson, 1212 University, Berkeley

According to the Baker report, you and your
Committee for the Indefinite Period of the
Government, which were only recently made
available to you. I should point out there are two
sections of this report: The general summary which you
have at hand, and a detailed plan for a possible
program in Washington. This detailed plan has been
submitted to your Research Department.

The people here, as you know, are

representative of many different disciplines including
that there is a growing feeling and that all groups
dealing with health matters that priority number one
in the matter of what needs, health needs, is that of
rehabilitation. The medical profession, the education

recommending this trend towards total medical care and



1 the futility of individual conflicting approaches and
2 programs have joined together here in Saskatchewan so
3 that the medical profession and other professional groups,
4 voluntary agencies and government agencies have formed
5 a Co-ordinating Council on Rehabilitation.

DDD/ 1 6 The Co-ordinating Council on Rehabilitation
7 is an independent federation of organizations concerned
8 with the rehabilitation of persons with disabling con-
9 ditions. The Council, as such, does not administer
10 services directly to the individual in need. It serves
11 the health, welfare, education, recreation, and re-
12 habilitation agencies and professions which provide ser-
13 vices to the disabled.

14 Some forty province-wide organizations
15 are members of the Council, of which about half are
16 voluntary, and the balance divided between professional
17 associations and government agencies.

18 In order to restore handicapped persons
19 to a level adequate for them to maintain their place in
20 society with minimal dependence on others, the Co-or-
21 dinating Council on Rehabilitation has adopted the
22 following objectives:

- 23 1. The promotion, development and integration of
24 a realistic, comprehensive rehabilitation program
25 for Saskatchewan by,
 - 26 (a) determining the needs for rehabilitation;
 - 27 (b) evaluating existing rehabilitation services;
 - 28 (c) developing a broad, over-all plan of action.
- 29 2. Advising and encouraging agencies to accept the
30 necessary responsibility in order to achieve the



1 above objectives.

2 The methods employed by the Council to accomplish these
3 objectives include:

4 (a) gathering factual data;

5 (b) serving as a forum or medium for obtaining agree-
6 ment regarding matters of rehabilitation;

7 (c) providing necessary machinery to facilitate the
8 flow of cases to services;

9 (d) assisting in the planning and development of new
10 projects; and

11 (e) providing educational activities to gain public
12 awareness and support of the rehabilitation pro-
13 gram carried out by the member organizations of
14 the Council.

15 The wide range of issues and problems are
16 handled by means of a Board of Directors, Secretariat,
17 Divisions and Committees as shown in the flow chart .

18 Subject of the Brief

19 This document focuses attention on three
20 major areas:

21 (a) It delineates the reason for developing medical
22 rehabilitation services as an integral aspect
23 of adequate medical and hospitalization care;
24 it recommends a model program for one province
25 (Saskatchewan) based on a (seven-year) develop-
26 mental pattern.

27 (b) While primary consideration is placed on the
28 medical aspects of rehabilitation, this brief
29 emphasizes the inter-dependence of the educational,
30 social and vocational areas. If these areas are



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(b) While primary consideration is placed on the

medical aspects of rehabilitation, this brief

emphasizes the inter-dependence of the education



1 not developed in unison, the results of medical
2 restoration are only partially effective and
3 sometimes negated.

4 (c) It discusses the importance of co-ordinated
5 effort and the respective roles of the national,
6 voluntary, and federal governments in the field
7 of total rehabilitation.

8 The Concept of Rehabilitation

9 Good rehabilitation is an organized
10 application of the appropriate techniques which will help
11 the individual to become as personally independent as
12 possible in spite of injury, disease or congenital defect.
13 The specialized techniques of rehabilitation involve the
14 co-operative activities of many professions, including
15 physicians, both family doctors and specialists, nurses,
16 physiotherapists, occupational therapists and speech
17 therapists, social workers, psychologists, teachers and
18 vocational placement officers, as well as the families
19 of patients, employers, and voluntary services in the
20 community, and the public at large.

21 Significance of Rehabilitation in an Adequate Health Care 22 Program

23 Rehabilitation must not be regarded
24 primarily as a service for "crippled" children and
25 adults, but rather as an essential element of good medical
26 care. This is particularly true of such common diseases
27 as result in slow recovery or chronic invalidism --
28 heart conditions, arthritis, accident cases, mental
29 illness, etc. To be effective, rehabilitation must
30 begin during the early medical care of the patient, and it



(c) It discusses the importance of co-ordinated effort and the respective roles of the national, voluntary, and federal governments in the field

The Concept of Rehabilitation

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application of the appropriate techniques which will help the individual to become as personally independent as possible to spite of injury, disease or congenital defect. The specialized techniques of rehabilitation involve the co-operative activities of many professions, including physicians, both family doctors and specialists, nurses, physiotherapists, occupational therapists and speech

recreational placement officers, as well as the families of patients, friends and, and voluntary services in the community, and the public at large. Significance of Rehabilitation in an Adequate Health Care

Rehabilitation must not be regarded

merely as a service for "crippled" children and

adults, but rather as an essential element of good medical care. This is particularly true of such common diseases as result in slow recovery or chronic invalidism -- heart conditions, arthritis, accident cases, mental



1 must be an integral part of any program for better
2 health services.

3 The restoration, wholly or partially,
4 of disabled persons to a greater degree of independence
5 can minimize unnecessary suffering by persons whose
6 physical deterioration can be prevented or ameliorated,
7 or whose disability can be improved if reached early with
8 rehabilitation measures.

9 Many analyses amply illustrate the
10 economic value of rehabilitation to society:

11 1.) It reduces the need for maintenance of persons on
12 public assistance and thus eases our tax burden.
13 As one of the many examples, the records of 71 cases
14 rehabilitated last year in Saskatchewan¹ show
15 that, before rehabilitation, it cost the taxpayer
16 \$54,580 annually to support these persons and their
17 dependants in various forms of public assistance;
18 following rehabilitation many ceased to be
19 liabilities and each earned, on an average, just
20 under \$2,000 a year, or a total of approximately
21 \$131,000.

22 It can further reduce loss of earnings and, in
23 many instances, avoid the need for public assistance;

24 2) Rehabilitation can result in greater utilization of
25 hospital facilities by freeing hospital beds more
26 rapidly;

27 3) It reduces dependency on others and enhances the
28 physical, psychological and social well-being of
29 the individual -- not only for the so-called disabled,

30 ¹Statistical analyses from the office of the
Saskatchewan Provincial Co-ordinator of Rehabilitation



1 must be an integral part of any program for better

2 The restoration, wholly or partially,

3 of disabled persons to a greater degree of independence

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7 rehabilitation measures.

8 Many analyses apply illustrate the

9 economic value of rehabilitation to society:

10 1) It reduces the need for maintenance of persons on

11 public assistance and thus eases our tax burden.

12 As one of the many examples, the records of 13 cases

13 rehabilitated last year in Saskatchewan show

14 that, before rehabilitation, the cost the taxpayer

15 \$24,500 annually to support these persons and their

16 dependants in various forms of public assistance;

17 following rehabilitation many ceased to be

18 disabled and each earned, on an average, just

19 under \$2,000 a year, or a total of approximately

20 \$121,000.

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22 many instances, avoid the need for public assistance;

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24 2) It reduces dependency on others and enhances the

25 physical, psychological and social well-being of



1 but also for that large segment of our population,
2 the chronically ill and the aged.

3 In spite of a very considerable develop
4 ment of a variety of rehabilitation services across the
5 nation, the majority of persons in need of medical rehab-
6 ilitation are still without, or are receiving, only
7 superficial services, due in most part to:

- 8 (a) lack of acceptance of the principles of rehabilita-
9 tion, both in professional circles, and by the
10 community;
11 (b) Lack of facilities, especially within the regular
12 health, welfare and education programs.
13 (c) Lack of adequately trained personnel;
14 (d) Lack of resources to train staff;
15 (e) Lack of co-ordination of the existing resources.

16 General Recommendations Concerning Development of Total
17 Rehabilitation Services

18 The organizations supporting this brief
19 contend that the lack of adequate rehabilitation resources
20 is a primary deficiency in current medical and hospital
21 care services for the sick and disabled in Canada. They
22 further submit that it is within the present means of the
23 nation to provide adequate services, for the following
24 reasons:

- 25 (a) It is a costly failure not to provide the necessary
26 services. The economic loss alone far exceeds the
27 costs of the services needed.
28 (b) Any increased expenditures for the development of
29 rehabilitation services will be offset by reduced
30 demands for in-patient hospital facilities.



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services. The economic loss alone far exceeds the
costs of the services needed.
- (b) Any increased expenditures for the development of
rehabilitation services will be offset by reduced



1 (c) Adequate rehabilitation services need not be costly.
2 Most of the necessary staff and facilities can and
3 should be developed within the regular health,
4 education and welfare framework. Many apparent
5 serious deficiencies can be resolved with the
6 addition of a few staff, re-allocation of facilities
7 and re-organization of administrative procedures.
8 Some additional expenditures must be expected, but
9 at the present time the most important element is
10 co-ordination and re-mobilization of presently
11 available resources.

12 The role of the Provincial Government in
13 Saskatchewan is described in Part II of this document.

14 General Recommendation #1:

15 The first recommendation is for the
16 development of a long-range detailed plan of action.
17 Basically this plan would emphasize the more efficient
18 use of present funds, staff, and resources rather than
19 a large expenditure of new monies.

20 The major deficiency is not lack of funds.
21 Instead, it is a problem of more efficient use of funds,
22 staff and resources, through complementary (rather than
23 duplicating and conflicting) utilization.

24 Such a comprehensive rehabilitation pro-
25 gram will not and cannot happen until an agreed-upon
26 long-range plan is evolved in which the Federal Govern-
27 ment departments and national voluntary organizations
28 have defined their respective long-range functions and
29 goals.

30 General Recommendation #2:



Most of the necessary staff and facilities can and should be developed within the regular health.

addition of a few staff, re-allocation of facilities and re-organization of administrative procedures. Some additional expenditures must be expected, but at the present time the most important element is co-ordination and re-mobilization of presently available resources.

The role of the Provincial Government in Siam is described in Part II of this document. Some of the recommendations are:

The first recommendation is for the development of a long-range detailed plan of action. Basically this plan would emphasize the more efficient use of present land, staff, and resources rather than a large expenditure of new money.

The major difficulty is not lack of funds. Instead, it is a problem of more efficient use of funds, staff and resources, through complementary (rather than duplicating and conflicting) utilization.

Such a comprehensive re-organization program will not and cannot expect to be an overnight long-range plan is evolved in which the Federal Government departments and national voluntary organizations have defined their respective long-range functions and



1 This organization contends that the
2 development of additional provincial services could be
3 greatly stimulated by direct Federal Government grants to
4 both provincial departments of Government and voluntary
5 agencies.

6 The rehabilitation grants established
7 by the Department of National Health and Welfare contri-
8 buted very significantly to, and accelerated, the develop-
9 ment of medical rehabilitation in Canada. The non-
10 matching feature of certain grants such as those for staff
11 training, is a vital feature.

12 It is logical that the national authorities
13 should take the initiative in stimulating program develop-
14 ment. For example, since adequate staff is the essence
15 of a rehabilitation service, non-matching federal grants
16 will assure early provincial co-operation regardless of the
17 financial situation of that province.

18 Grants need to be made available for the
19 development of training schools for physical and occupa-
20 tional therapy, for rehabilitation counsellors, for
21 special placement services, for physical medicine facilities
22 in general hospitals, home-care programs, and sheltered
23 workshops.

24 It should be emphasized that non-shareable
25 grants, (or a minimum ratio of 75:25 federal-provincial
26 sharing arrangement) would at this time help strengthen
27 critical weaknesses in present services.

28 The United States Office of Vocational
29 Rehabilitation has demonstrated the value of this
30 approach in both medical and vocational areas and has



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approach to both medical and vocational areas and has



1 advanced the cause of rehabilitation significantly in
2 relation to expenditures. The O.V.R. policy is that
3 grants are available not on the basis of jurisdiction,
4 but on the basis of merit. Voluntary agencies can
5 participate more directly and, consequently, much basic
6 and vital pilot program type of work has been undertaken.

7 The Canadian Government is to be
8 commended for its own contributions in this respect in
9 certain areas, especially medical rehabilitation. An
10 expansion of the United States Office of Vocational Re-
11 habilitation approach would greatly stimulate development
12 in such critical areas as sheltered work and research.

13 General Recommendation #3

14 The Co-ordinating Council submits that
15 the co-ordination of national efforts in rehabilitation
16 between Federal Government departments, between voluntary
17 agencies, and between the voluntary agencies and the
18 Federal Government would lead to more effective programming.

19 At the present time, where each department
20 of the Federal Government and each voluntary organization
21 operates, for the most part, independently and often in
22 isolation, this has resulted frequently in unbalanced
23 program development, contradictions and duplications.

24 This has a marked negative effect on provincial re-
25 habilitation programs in that it makes for fragmentation
26 of effort, for unduly complex administration, and makes
27 co-ordination on the provincial level difficult.

28 Examples:

29 (a) Special placement services are provided by the
30 federal government for certain individuals but not



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23 which has a marked negative effect on provincial ve-
24 habilitation programs in that it makes for fragmentation
25 of effort, for overly complex administration, and makes
26 co-ordination on the provincial level difficult.
27 Examples:
28 (a) Special placement services are provided by the
29 Federal Government for certain individuals but not



1 for others, yet both have been rehabilitated and
2 trained under federal government agreements.
3 (b) It is possible to obtain non-matching grants to train
4 social workers who work in medical setting, but not
5 for social workers who work in a social-vocational
6 setting - though both may be doing essentially the
7 same kind of work.

8 In Saskatchewan the medical and physical
9 restoration programs have prepared many individuals for
10 the next stage only to find that they are unable to dis-
11 charge them for lack of social-vocational resources,
12 and particularly for lack of staff to do the special
13 placements. Many cases are on the rosters of rehabili-
14 tation agencies whose status is "rehabilitated and fit
15 for work, but as yet, unemployed."

16 The problem is not simply a matter of
17 necessarily consolidating all rehabilitation efforts under
18 one department, since good rehabilitation concerns the
19 programs of many departments.

20 The federal government departments have
21 attempted some co-ordination through a National Advisory
22 Committee on Rehabilitation responsible to the Minister
23 of Labour. It is, however, an advisory body to a particular
24 department rather than an effective co-ordination device.
25 The problem of effective co-ordinating machinery has been
26 given much attention in Saskatchewan and, at present,
27 two interlocking organizations exist:

28 (a) an Interdepartmental Co-ordinating Committee on
29 Rehabilitation which is intra-governmental and deals
30 with internal government matters;



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 Rehabilitation which is intra-governmental and deals
 with internal government matters;



1 (b) the Co-ordinating Council on Rehabilitation
2 (Saskatchewan). This is a federation of private
3 agencies, professional associations, provincial and
4 federal government departments, all concerned with
5 the rehabilitation of persons with disabling con-
6 ditions. This "agencies' agency" has been most effective
7 in creating a positive working climate, and is now
8 beginning to have a very direct influence in meshing
9 inter-agency efforts, in long-term planning, and in
10 gradually remoulding the Saskatchewan rehabilitation
11 program.

12 The structure of the organization permits
13 a variety of problems to be processed simultaneously
14 through a series of specialized groups and sub-
15 groups as shown in the attached flow chart (frontis-
16 piece).

17 While the role of the national voluntary
18 organizations and the federal government departments differs
19 from that of provincial rehabilitation organizations, the
20 need at the federal level is the same for mutual planning
21 and negotiation, and for complementary effort.

22 The third general recommendation, therefore
23 is for the development of a National Co-ordinating Council
24 on Rehabilitation involving all agencies (government
25 and non-government) concerned with rehabilitation. This
26 needs to be supplemented by an intra-governmental com-
27 mission or advisory board on rehabilitation matters,
28 directly responsible to the Prime Minister. The chief
29 functions of the latter would be to bring about a balance
30 in the various aspects of rehabilitation in which the



the Co-ordinating Council on Rehabilitation
(Saskatchewan). This is a federation of private
federal government departments, all concerned with
the rehabilitation of persons with disabling con-
ditions. This "agencies' agency" has been most effective
in creating a positive working climate, and is now
beginning to have a very direct influence in meaning-
fully remedying the Saskatchewan rehabilitation
program.
The structure of the organization permits
a variety of problems to be processed simultaneously
through a series of specialized groups and sub-
groups as shown in the attached flow chart (enclosed).

While the role of the national voluntary
organizations and the federal government departments differs
from that of provincial rehabilitation organizations, the
need at the federal level is the same for social planning,
and negotiation, and for complementary efforts.

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needs to be supplemented by an intra-governmental com-
mission or advisory board on rehabilitation matters,
directly responsible to the Prime Minister. The chief
functions of the latter would be to bring about a balance
in the various aspects of rehabilitation in which the



1 federal government is involved, and to advise on priorities
2 of future action.

3 Specific Recommendations Regarding Medical Rehabilitation

4 The Co-ordinating Council on Rehabilitation
5 and its member agencies are cognizant of the problems
6 to be faced in realizing a full-scale national medical
7 rehabilitation program and, therefore, recommends a long-
8 range but positive plan graduated to the nation's ability
9 to mobilize the necessary resources.

10 Part II of this document outlines a master
11 plan for the development of a medical rehabilitation
12 program in the province of Saskatchewan.

13 We respectfully submit that though this
14 blueprint has been designed to meet the particular needs
15 of this province, it is applicable to the other provinces
16 with respect to the basic precepts enunciated, the
17 formulae suggested for staff and facility requirements,
18 the methods of financing, and the relationships of the
19 program to regular medical, hospital, educational, psycho-
20 social, and vocational services in the community.

21 The following primary action is required
22 by the Government of Canada to realize an adequate
23 medical rehabilitation program (as outlined in Part II):

24 (a) Within its program of supporting hospitalization
25 services, the Federal Government should grant
26 priorities and increased financial incentive to
27 support renovations and extension and equipping of
28 hospital facilities for physical therapy in all
29 hospitals of fifty beds or more; and physical
30 medicine departments in larger hospitals.



1 (b) Provide even greater incentive for provinces to
2 develop out-patient services with an emphasis on
3 intra mural and extra-mural (home-care) rehabilitation
4 services to all patients without discrimination as
5 to in- or out-patient benefits. In this way, out-
6 of-hospital care is not made less attractive
7 than in-hospital or institutional care. An in-
8 tensified public and professional education program
9 needs to be inaugurated to encourage the intro-
10 duction and organization of home-centered programs
11 in base and regional centres throughout the
12 country.

13 (c) There should be an increased emphasis on medical
14 rehabilitation in the teaching of both medical and
15 nursing students, as well as clinical experience.
16 More educational opportunities and clinical
17 practice are needed for those presently in practice.

18 (d) Inherent in the realization of the above program
19 is the need for more funds or training students in
20 the rehabilitation professions. No rehabilitation
21 program can succeed, regardless of the adequacy of
22 any other provisions, without solving the critical
23 problem of staff supply. One of the surest ways
24 is the establishment of more schools in Canada for
25 speech, physical therapy, and rehabilitation
26 counsellors.

27 There are many other associated needs which are outlined
28 in greater detail in Part II.

29 Relationship and Need of other Rehabilitation Programs to
30 Medical Care and Medical Rehabilitation.



1 In the development of the medical re-
2 habilitation scheme, government and voluntary organiza-
3 tions must strive for balanced program growth; otherwise,
4 the benefits realized by physical restoration are diminished
5 or lost through lack of opportunity to achieve social
6 and economic independence.

7 There are many areas of unmet needs whose
8 development must parallel expansion of medical rehabilitation
9 services. The undernoted are key problems which are
10 the mutual responsibilities of government and non-govern-
11 ment organizations. The needs include:

12 (a) more psychological and vocational assessment services
13 on a regional basis;

14 (b) more field staff to help re-establishment of the
15 post-psychotic, the mentally retarded, and the
16 physically handicapped with multiple involvement,
17 into the community;

18 (c) more special placement officers are urgently needed.

19 The National Employment Service, while gradually
20 increasing its staff, is still not equipped to do
21 the intensive type of work required in the placement
22 of the more seriously disabled (who are difficult
23 to place but can be located into part - or full-
24 time employment) following rehabilitation.

25 (d) more vocational adjustment centres and sheltered
26 workshops are required on both a regional and
27 central level for the various types of disabilities.

28 (e) more accommodation for out-of-town cases receiving
29 assessment and treatment services at the centrally-
30 located points.



In the development of the medical re-

time must arrive for balanced program growth; otherwise, the benefits realized by physical restoration are diminished or lost through lack of opportunity to achieve social and economic independence.

There are many areas of human needs whose development must parallel expansion of medical facilities and services. The coordinated and key programs which are the mutual responsibilities of government and non-government organizations. The need - include:

- (a) more psychological and vocational assessment services on a regional basis;
- (b) more field staff to help re-establishment of the post-psychotic, the mentally retarded, and the physically handicapped with multiple involvement into the community;
- (c) more special placement officers are urgently needed. The National Employment Service, while presently functioning as staff, is still not equipped to do the extensive type of work required in the placement of the severely disabled (who are difficult to place but can be trained into part - or full-time employment) following rehabilitation.
- (d) more vocational adjustment centers and sheltered workshops are required on both a regional and central level for the various types of disabilities.
- (e) more accommodation for out-of-town cases receiving assessment and placement services at the centrally-located points.



- 1 (f) special up-grading (academic and vocational
2 opportunities for a large segment of disabled people
3 whose successful rehabilitation is delayed or pre-
4 vented because of low educational status. There is
5 little hope of realizing vocational independence
6 unless the special vocational education opportunities
7 are made available. There is need for an incentive
8 plan on the part of the federal government (such as
9 the 75 per cent shareable arrangements of Schedule M)
10 to stimulate development of these programs in the
11 provinces. In this regard, federal support is re-
12 quired in the development of junior technical or
13 vocational schools for senior-age retarded and
14 multiple disability cases. The cost of equipping
15 schools of this kind is usually less than for
16 equipping composite and technical schools since the
17 vocational activities are generally of a simpler
18 nature. In many such schools, students work part-
19 time and go to school for the balance of the day,
20 and the school program is based upon needs seen in
21 employment.
- 22 (g) much more needs to be done in the detection and re-
23 habilitation of pre-school children with auditory and
24 visual impairments in order to prevent the need for
25 more specialized teaching and training institutions.
- 26 (h) Since it can be amply demonstrated that the develop-
27 ment of the non-medical aspects of rehabilitation
28 must parallel the medical phase, there should be
29 no discrimination in the provision of federal grants
30 for these programs. This discrepancy presently



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time for the school for the balance of the day,
and the school program is based upon needs seen in
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Much more needs to be done in the selection and re-
habilitation of the school children with auditory and
visual handicaps in order to prevent the need for
more specialized teaching and training institutions.
Since it can be easily demonstrated that the develop-
ment of the non-medical aspects of rehabilitation
must parallel the medical phase, there should be
no discrimination in the provision of federal grants
for these programs. This discrepancy presently



1 exists with regard to capital grants for social--
2 vocational rehabilitation. Example: construction
3 grants for work-conditioning centres and sheltered
4 workshops. Assistance in capital grants in this
5 area is desperately needed to cope with the growing
6 problem of rendering services to the marginally-
7 disabled.

8 (1) Finally, the effective and progressive rehabilitation
9 programs are dependent on adequate opportunity and
10 funds for research. In this regard the approach
11 adopted by the United States Office of Vocational
12 Rehabilitation, in encouraging research on a broad
13 basis, has proven its worth. A similar approach
14 is needed in Canada - with one modification: A
15 national rehabilitation advisory research council
16 or board should be established to assure co-ordination
17 of funds and resources. Such a body might be
18 attached to the proposed National Rehabilitation
19 Council or to an existing research advisory body
20 within the Federal Government.

21 These recommendations are the result of
22 considerable study and experimentation by the Co-ordinating
23 Council. If adopted they would establish the basis for
24 an effective and comprehensive rehabilitation program in
25 Canada without extensive expenditure of additional funds.

26 May I say that we have all been very
27 pleased with the Prime Minister's announcement that the
28 additional ten million dollars in pension to the disabled
29 that has been made available. Another ten million
30 dollars in basic rehabilitation services would, I am sure,



1 do much more in revising the total needs, the total costs
2 of any disability program which the Government has to
3 underwrite.

4 THE CHAIRMAN: Thank you very much,
5 Dr. Buckwold. Just having listened to your submission
6 impresses one with the care that has gone into its
7 preparation and the time that has been devoted to making
8 available a document which will be of great use to this
9 Commission.

10 COMMISSIONER GIRARD: Mr. Chairman, my
11 question is, Dr. Hunt, in relation to rehabilitation,
12 you know that the V.O.N. have a home-care program and I
13 understand that home care is one of your projects but
14 whether you differ somewhat in the application for home
15 care I think maybe you can just tell us about it.

16 DR. HUNT: Mr. Chairman and Miss Girard:
17 certainly with home care or what we might better term
18 organized home care is one of the more exciting aspects
19 of general health services which is developing in
20 Canada now and might lead to a state in which we need
21 far fewer hospital beds than my honoured colleagues of
22 yesterday may have indicated. Of course, perhaps we
23 may need some more.

24 Certainly it is a method of caring for
25 people by aminiature hospital in the patient's own home
26 and it provides more service than an individual or an
27 individual's nursing agency can offer by providing a
28 multiplicity of services which heretofore were only
29 available in the hospital.

30 We have been pleased to have received a



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 and it provides more service than an individual or an
 individual nursing agency can offer by providing a
 multiplicity of services which heretofore were only
 available in the hospital.

We have been pleased to have received a



1 grant of money to do a study at the University Hospital
2 to see whether rehabilitation can be done in the home
3 as well as just domiciliary care for the group which
4 you might call the chronic. We have found this to be rea-
5 sonably successful. I did not bring all my figures with me
6 on Monday when I came to see you but roughly between
7 65 percent and 75 percent of patients can be made in-
8 dependent in their own homes. It has reached that stage
9 on rehabilitation where they become not only useful
10 citizens but do not need care from other people. A
11 smaller number or additional number may only need some
12 resource institute, total incidental care or total
13 home care work which is just a once a week visit from a
14 nurse. We feel that hospital base programs are
15 superior and in this way I would caution against perhaps
16 placing with home-care service or recommendations on
17 all home-care service as being placed under departmental
18 public health or preventative medicine resources. I
19 think it must be more flexible than that. In some
20 areas individually a community base program works out
21 well. This has not been the experience in the majority
22 of centres but rather they must be based from the hospital
23 because this gives more continuous care; the patient
24 goes from the acute ward to the more chronic ward and
25 so into the home with the same group of people tying
26 in. Of course, the nurse on the ward does not look
27 after the person in the home but the co-ordinator does
28 and that should be a public health nurse or a doctor
29 depending on the size of the unit.

30 I know Miss Girard is very interested in



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to see whether rehabilitation can be done in the home
as well as in a domiciliary care for the group which
you might call the chronic. We have found that to be re-
sulting from the fact that I came to see you but roughly between
60 percent and 75 percent of patients can be made in-
dependent in their own homes. It has reached that stage
on rehabilitation where they become not only useful
patients but do not need care from other people. A
smaller number of patients would only need some
resources in the hospital, but the majority of them
home care work which is just a once a week visit from a
nurse. We feel that hospital care is not the best
solution and in this way I would rather prefer patients
living with their own families or in residential care
if home care service is being planned under departmental
public health or preventive medicine resources.
I think it must be more flexible than that. In some
cases, individually a community care program works out
well. This has not been the experience in the majority
of cases but rather they have been based from the hospital
and this has been a serious error; the content
given from the home ward to the home chronic ward and
so into the home with the same group of people living
in. Of course, the nurse in the ward does not look
after the person in the home but the co-ordinator does
and that would be a public health nurse or a doctor
depending on the size of the unit.



1 figures so I phoned back to my office and got these
2 figures for you. Our project in the first 18 months
3 was limited to studying ten patients at any one time.
4 In that time we provided 5,069 patient days of care
5 at an average daily rate of less than \$4.00 which is a
6 considerable saving on any institution and particularly
7 the acute hospital where patients with chronic disabilities
8 may reside at the cost of \$24.00, \$25.00 and even \$30.00
9 a day.

10 COMMISSIONER GIRARD: Well then, Dr.
11 Hunt you are satisfied that there is a saving of money.
12 If you remember when the Montefiore Hospital Plan came
13 out at the hospital in New York a few years ago and there
14 was a big cry that it was going to save money; if they
15 did not save money at least they would save beds in the
16 hospital. Now you are satisfied it also saves money?

17 DR. HUNT: I won't go that far. You
18 give more service for less money; you do not save money,
19 you spend more money but you give more service at a
20 cheaper rate by having a home-care service. We have
21 raised our service from 21 beds to over 32 beds at no
22 capital cost and these ten beds are at least cheaper
23 than the 22 to run in proportion.

24 COMMISSIONER GIRARD: This \$4.00 a day,
25 it would mean you would not have more than one worker
26 going in per day? Some day the nurse would go in and some
27 day the social worker and you would not have a home-
28 maker in all the time on these cases?

29 DR. HUNT: The family provides a nursing
30 aide type of service that is given in the hospital.



1 COMMISSIONER GIRARD: Thank you.

2 COMMISSIONER VAN WART: Do you find that
3 apartment house living is a detriment to this home
4 nursing program?

5 DR. HUNT: We don't have too many people
6 in Saskatoon who live in apartments. We haven't found
7 too much difficulty. It depends on how the apartment
8 is constructed, and what the disability is. If the
9 person is limited to a wheelchair, they are limited to
10 the ground floor of the apartment. I might say the
11 majority of our cases have been older citizens, with
12 strokes, and we feel certainly that this type of home
13 care is one solution to the need for geriatric beds.

14 COMMISSIONER VAN WART: Before the intro-
15 duction of hospital plans, the statement was made that
16 apartment living was a cause of increased admissions to
17 hospital on account of no accommodation for sick people
18 in the apartment.

19 DR. HUNT: It certainly is a detriment
20 in certain conditions. A paraplegic in a wheelchair
21 would have a very poor time, but we have one who has
22 to have an electric wheelchair, whose apartment landlord
23 allowed them to make a ramp into a parking lot next door,
24 so I think the techniques of rehabilitation, the philosophy
25 of rehabilitation, have let us see where people can live
26 in situations which before were considered to be
27 impossible.

28 THE CHAIRMAN: Have you anything to add,
29 Dr. Bachynski?

30 DR. BACHYNSKI: No, unless there are any

COMMISSIONER GIBBARD: Thank you.

COMMISSIONER VAN KAT: Do you find that

apartment house living is a detriment to this home

housing program?

DR. HUNT: We don't have too many people

in Saskatoon who live in apartments. We haven't found

too much difficulty. It depends on how the apartment

is constructed, and what the accessibility is. If the

person is limited by a wheelchair, they are limited to

the ground floor of the apartment. I might say the

majority of our cases have been older citizens, with

seniors and so forth, certainly that type of home

is not suited to the need for geriatric care.

COMMISSIONER VAN KAT: Before the intro-

duction of capital plan, one of the main things that

apartment living was a cause of increased attention to

hospital on account of a recommendation for sick people

in the apartment.

DR. HUNT: It certainly is a detriment

in certain conditions. A paragraph in a wheelchair

would have a very poor time, but we have one who has

to have an electric wheelchair, whose apartment landlord

allowed them to make a ramp into a parking lot next door,

so I think the conditions of rehabilitation, the philosophy

of rehabilitation, have let us see where people can live

in situations which before were considered to be

impossible.

THE CHAIRMAN: Have you anything to add?

Dr. Propoyevsky



1 questions I can answer, I think it is pretty well covered
2 in the Brief, Sir.

3 COMMISSIONER STRACHAN: In speaking
4 of the number of days that this home care service is
5 given, what part of the day is occupied in rendering
6 it? You don't mean full days?

7 DR. HUNT: Well, the person is being
8 looked after for 24 hours a day by somebody.

9 COMMISSIONER STRACHAN: Right in the
10 home?

11 DR. HUNT: Mostly by the family, but
12 as far as professional service, this works out to a
13 little more than an hour a day of professional service,
14 and that is all that is necessary.

15 COMMISSIONER STRACHAN: But you are
16 calling that a day, when you speak of 5,000 days?

17 DR. HUNT: Well, that is a professional
18 day, but you will remember that in a hospital a pro-
19 fessional day is only about three hours too.

20 THE CHAIRMAN: For the nurses it was
21 3.4.

22 DR. HUNT: I said about.

23 COMMISSIONER BALTZAN: Dr. Hunt, on
24 page 2, your report of your experience with the 71
25 cases is most exciting. You turned a liability into
26 an asset, and in addition you also afforded hope and
27 happiness. Now, could you tell me what was the
28 average cost of treatment per individual?

29 DR. HUNT: Can I refer that to Dr.
30 Roeher?



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DR. HUNT: Not in the family, but

as far as professional service, it is works out to a

little more than an hour a day of professional service,

and that is all that is necessary.

COMMISSIONER STRACHAN: But you are

saying that a day costs you about \$2,000 a day?

DR. HUNT: Well, that is a professional

day, but you will remember that in a hospital a pro-

fessional day is only about three hours too.

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on assets, and in addition you also offered hope and

inspiration. Now, could you tell me what was the

average cost of treatment per individual?

DR. HUNT: You refer that to Dr.



1 COMMISSIONER BALTZAN: Please do.

2 DR. ROEHER: It is a little difficult
3 to get accurate figures on these, because these cases
4 may go through many programs, including hospitalization
5 and private medical care, but according to the cost
6 to an agency, formal rehabilitation, the average cost
7 for these cases is running roughly at \$4,000. per case.
8 This is much higher than should be the situation,
9 because most of these people are so badly involved when
10 we get them that you have long-term training programs
11 for them, often up-grading in academic, and all the
12 range, so it is considerably higher than it should be.
13 Interestingly enough, it is the contention that our
14 programs are still sporadic, with serious gaps. These
15 71 cases were taken out of a total analysis of 960
16 cases, which were closed by agencies as having done
17 as much as they could, and only 368 of these were re-
18 habilitated to a successful degree. The balance, for
19 one reason or another, were still a failure, or only
20 helped partially. So we are dealing with a fairly
21 serious situation.

22 COMMISSIONER BALTZAN: Yes, but in
23 spite of that you bring relief, and the person comes out
24 with a profit and a benefit.

25 DR. ROEHER: Yes. Most of these cases ,
26 if reached at the time that they have the greatest
27 potential, could possibly be helped, but getting them
28 at 16 years of age, or 22, or even when motivation is
29 so low that you can do little with them, creates the
30 difficulty.



It is a little difficult to get accurate figures on cases, because there are many different types of cases, including hospitalization and private medical care, but according to the cost to an agency, for example, the average cost for these cases is running roughly at \$4,000 per case. This is much higher than should be the situation, because most of these people are so badly involved when we get them that you have long-term training programs for them, often extending in academic, and all the things, so it is considerably higher than it should be. I think it is enough, it is the condition that our programs are being operated, with serious gaps. These cases are about one of a total of 500 cases, which were closed by agencies as having done as much as they could, and only 50 of these were re-rehabilitated in a successful manner. The balance, for one reason or another, were still a failure, or only partially. So we are dealing with a fairly serious situation.

COMMISSIONER BALKMAN: Yes, and in spite of that you being helped, and the person comes out with a profit and a benefit. It is reached at the time that they have the greatest potential, could possibly be helped, but getting them at 10 years of age, or 25, or even when motivation is at low that you can do little with them, creates the



1 THE CHAIRMAN: You are really only an
2 infant, are you not Doctor?

3 DR. BUCKWOLD: Yes, I am only a paediatrician.
4

5 THE CHAIRMAN: No, I mean --- perhaps
6 I should have said youth.

7 DR. BUCKWOLD: Yes, this is true.

8 THE CHAIRMAN: The organization is what,
9 about a year old?

10 DR. BUCKWOLD: Yes, about two years old,
11 but the organizations who have been doing this work
12 have been here for much longer, and of the 960 cases
13 that Dr. Roeher just reported on, 254 of them had to be
14 rejected from starting in any program at all, due to
15 in many instances the time lag between referral or
16 accident and the development of disability.

17 THE CHAIRMAN: Now, you told us that
18 this Co-ordinating Council does not do any of the
19 actual rehabilitation work itself, it is a Co-ordinating
20 Council. Can you give us any specific instance where
21 from the fact of co-ordination something was done which
22 would not otherwise have been done? We are concerned
23 with the justification of the existence of your
24 organization as another one to the other 50.

25 DR. BUCKWOLD: This is a very good point.
26 We have a few concrete examples. For example, there is
27 a need, as you have heard in the medical brief and in
28 other briefs, a great need for investigation of the hard
29 of hearing and the speech defects. Through the
30 auspices of the Co-ordinating Council, various organizations



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a need, as you have heard in the medical world in

other fields, a great need for investigation of the

of hearing and the speech defects. Through the

members of the Co-ordinating Council, various organizations



1 who could contribute to such a program were gathered
2 together and co-ordination of the various centres, Red
3 Cross, and government and so forth, and went into the
4 region at Humboldt, and the last summer conducted a very
5 successful program there, indicating that this need
6 exists, that we have a method of satisfying a need whereby
7 various agencies can work together in providing this
8 service. This is the purpose of the Co-ordinating
9 Council. It works for example, another instance occurred
10 just recently, where the Cysticfibrosis Association was
11 interested in establishing in the Province of Saskatchewan.
12 The Co-ordinating Council, by calling together the various
13 agencies now working with children with Cysticfibrosis,
14 called together the Association for Crippled Children,
15 the Red Cross, the Physiotherapists Group, and between
16 them we have worked out a program whereby the Cystic-
17 fibrosis Association does not have to establish another
18 organization with all the duplication of services and
19 therapy, so the existing organizations can do this within
20 their own framework, and the Cysticfibrosis Association,
21 according to a communication we received a few days ago,
22 is very happy with this type of situation.

23 COMMISSIONER BALTZAN: You can extend
24 that to include the amputees.

25 DR. BUCKWOLD: Oh yes. Dr. Hunt has
26 an Amputee Clinic. The Council for Crippled Children
27 will be running a prosthetic shop. The Government of
28 Saskatchewan is assisting with the payment, through
29 health grants, of some of our personnel, so that in this
30 Province no one will have to pay more than a \$100. for an

who could contribute to such a program were gathered together and co-ordination of the various centers. Now Gross, and government and so forth, and went into the region at Humboldt, and the last summer conducted a very successful program there, indicating that this need exists, that we have a method of satisfying a need where various agencies can work together in providing this service. This is the purpose of the Co-ordinating Council. It works for example, another instance occurred just recently, where the Gyroscopic Association was interested in establishing in the Province of Saskatchewan. The Co-ordinating Council, by calling together the various agencies now working with children with Gyroscopic etc.,

the Red Cross, the Physiotherapy Group, and between them we have worked out a program whereby the Gyroscopic Association does not have to establish another organization with all the duplication of services and therapy, so the existing organizations can do this within their own framework, and the Gyroscopic Association, according to a communication we received a few days ago, is very happy with this type of action.

There is also the question.

DR. BUCKWOLD: Oh yes, Dr. Hume has

an Amputee Clinic. The Council for Crippled Children will be running a prosthetic shop. The Government of Saskatchewan is assisting with the payment, through health grants, of some of our personnel, so that in this respect no one will have to pay more than a \$100. for an



1 artificial limb, as now arranged.

2 DR. HUNT: One thing you will be interested
3 in hearing Sir. This saved you from hearing 50 briefs.

4 COMMISSIONER BALTZAN: Nobody will be-
5 grudge you that monopoly either.

6 THE CHAIRMAN: How are you financed?

jb 2 7 DR. BUCKWOLD: We have very little
8 finances. We have a membership fee, which is very,
9 very small, to the various agencies. The larger agencies
10 have assisted with Hundred Dollar grants. We have some
11 help from the Department of Public Health, in the use of,
12 since their agencies are also members of this agency,
13 they assist in giving us office space, and none of
14 our ways are paid to these meetings.

15 THE CHAIRMAN: But you don't make a
16 public appeal?

17 DR. BUCKWOLD: We do not go to the public,
18 no.

19 COMMISSIONER STRACHAN: Mr. Chairman,
20 I am struck by the number of sponsoring agencies, and
21 going through the list, I see no mention of the Muscular
22 Dystrophy.

23 DR. BUCKWOLD: The Muscular Dystrophy
24 is associated with the Association for Crippled Children.
25 We have had to co-ordinate every agency we could.

26 I hate to press this point, but Dr.
27 Roeher is itching to say something about bursaries.

28 THE CHAIRMAN: He has the floor.

29 DR. ROEHER: This afternoon, Mr.

30 Chairman and Members of the Commission, just as I came



artificial limb, as now arranged.

DR. HUNT: One thing you will be interested

in hearing Sir. This saved you from hearing 50 briefs.

COMMISSIONER BATTAN: Nobody will be

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DR. BUCKWOLD: The Muscular Dystrophy

is associated with the Association for Crippled Children.

We have had to coordinate every agency we could.

I hate to press this point, but Dr.

Roeber is looking to say something about businesses.

THE CHAIRMAN: He has the floor.

DR. ROEBER: This afternoon, Mr.

Chairman and Members of the Commission, just as I came



1 in the question of bursaries came up, and you were
2 asking, is the bursary program effective, I believe.
3 So we phoned into the office and got some data, although
4 we can give you more complete substantiation of this.
5 We analysed the results of the bursary students in
6 public health, that is for therapists, mostly, also for
7 social work personnel, and there is an interesting
8 comparison. In occupational therapy, of 16 bursaries
9 awarded, 5 of these people are still in service. Two
10 of them failed to fulfill their agreement. In speech
11 therapy, four were awarded, and one of these failed to
12 honour their agreement. In the combined physical therapy
13 and occupational therapy course, nine were awarded. Two
14 are still in the program, and two failed to honour their
15 agreement. In physiotherapy, of 18 awarded, five are
16 still in service and five failed to honour their
17 agreement. In the social worker bursaries, under the
18 Department of Health and Welfare, of 18 bursaries awarded
19 for social work, 11 are still in the service, and only
20 two failed to honour their agreement, and on their
21 educational leave program, 43 were awarded. Thirty-two
22 are still in the field, and only two failed to honour
23 their agreement. I think this is rather interesting,
24 and it bears out that it is not a case of grants for
25 bursaries, but how these are implemented.

26 MR. TALBOT: One of the ones who failed
27 to honour his agreement went to another Department of
28 Government, and we wiped that application out. The
29 educational grants under our program, as a student who
30 works for us, after several months, or a year, or two

in the question of burseries came up, and you were asking, is the burseries program effective, I believe. So we phoned into the office and got some data, although we can give you more complete substantiation of this. We analyzed the results of the burseries program in public health, that is for therapists, mostly, also for social work personnel, and there is an interesting comparison. In occupational therapy, of 16 burseries awarded, 5 of these people are still in service. Two of them failed to fulfill their agreement. In speech therapy, four were awarded, and 3 of these failed to fulfill their agreement. In psychotherapy, of 16 awarded, five are still in service and five failed to fulfill their agreement. In the social work burseries, under the Department of Health and Welfare, of 16 burseries awarded for social work, 11 are still in the service, and only two failed to honor their agreement, and on their educational leave program, 43 were awarded, thirty-two are still in the field, and only two failed to honor their agreement. I think this is rather interesting, and it seems me that it is not a case of people for

MR. TAYLOR: One of the cases who failed

to honor his agreement went to another Department of Government, and we wiped that application out. The educational grants under our program, as a student who works for us, after several months, or a year, or two



1 years, and who shows promise of having the capability of
2 becoming a professional social worker, can be granted
3 educational leave. If he is a single person, he is
4 allowed \$200. a month, plus tuition fees, plus cost of
5 books, plus cost of transportation to and from the
6 University of his choice. If married, he is allowed
7 \$250. plus the same other gratuities, transportation,
8 cost of books, and full cost of tuition. In return for
9 this, if they are granted one year's leave for study,
10 they must sign an agreement to come back and work for the
11 Department for two years.

12 If they are granted two years concurrent
13 educational leave, which we do allow, they must sign an
14 agreement to work for the Department for three years,
15 and at the end of that time, if they have fulfilled their
16 obligations, they are free to seek employment anywhere.

17 THE CHAIRMAN: And they do not repay?

18 MR. TALBOT: And they do not repay. If
19 they have worked for us for the two or three years, we
20 feel they have fulfilled their obligation. We would
21 like to extend this, to encourage more people from private
22 agencies to come and be trained under our program, and
23 not having to work for the Government, but so far we
24 haven't been successful.

25 COMMISSIONER VAN WART: These are sort of
26 promotional bursaries, not exactly the initial bursaries,
27 for employment?

28 MR. TALBOT: No, we have two types.
29 This is educational. People who are already on staff,
30 and who are granted educational leave. If they have the

1 years, and who shows promise of having the capability of
2 becoming a professional social worker, can be granted
3 educational leave. If he is a single person, he is
4 allowed \$200 a month, plus tuition fees, plus cost of
5 books, plus cost of transportation to and from the
6 University of his choice. If married, he is allowed
7 \$250, plus the same other gratuities, transportation,
8 cost of books, and full cost of tuition. In return for
9 this, if they are granted one year's leave for study,
10 they must sign an agreement to come back and work for the
11 Department for two years.
12 If they are granted two years' leave, they must sign an
13 educational leave, which we do allow. They must sign an
14 agreement to work for the Department for three years,
15 and at the end of that time, if they have fulfilled their
16 obligations, they are free to seek employment elsewhere.
17 THE CHAIRMAN: And they do not repay.
18 MR. TALBOT: And they do not repay. If
19 they have worked for us for the two or three years, we
20 feel they have fulfilled their obligation. We would
21 like to extend this, to encourage more people from private
22 agencies to come and be trained under our program, and
23 not having to work for the Government, but so far we
24 haven't been successful.
25
26 promotional purposes, not exactly the initial purposes,
27 for employment?
28 MR. TALBOT: No, we have two types.
29 This is educational. People who are already on staff,
30 and who are granted educational leave. If they have two



1 educational qualifications to enter a school of social
2 work, that is B.A., or if they have the background they
3 would get a diploma rather than a degree.

4 COMMISSIONER VAN WART: In the latter class
5 you would have no difficulty in obtaining applicants for
6 the bursary, but in the former, where they are employment
7 bursaries, do you have difficulty getting applicants?

8 MR. TALBOT: No, we have more applicants
9 than we have bursaries. However, we are very selective,
10 and I think in relation to Dr. Roehrer's figures that he
11 gave you, we feel that perhaps this may be one of the
12 safeguards, that you should be very selective before
13 you really grant an educational leave. That is, that
14 you are sure that person has the capabilities of becoming
15 a good social worker, and to some extent that he wants
16 to make his life work in it.

17 DR. HUNT: These figures show an
18 important thing. Dealing with what I said in the
19 previous brief, that the successful people have been
20 far more mature persons, who have something to come back
21 to, that they want to come back to, and the training and
22 the bursary. It is a short period of time, but our
23 trouble in physical and occupational therapy is here.
24 We have a young man or girl, mostly young girls of 17
25 or 18 years of age, committing themselves for seven or
26 eight years, and I think this is, frankly, unrealistic,
27 and I think that should be brought out, the way the
28 bursaries are being run for that category.

29 THE CHAIRMAN: Mr. Bates, you are the only
30 one who has not said anything.



1 MR. BATES: Well sir, I am not a medical
2 man. I might as well admit I have special interests.
3 Particularly now I am thinking in terms of speech therapy
4 and hearing, and vision, because in our schools we re-
5 cognize the problems that arise, and I am becoming more
6 and more convinced as I work that we have to get at these
7 things at the earliest age possible, so that we don't
8 have as many deaf people, as many blind people, and
9 as many youngsters handicapped through speech disabilities,
10 because that is, well, as everyone knows, it is serious
11 to have in life, and presents serious educational problems.
12 We are finding, for example, that our School for the Deaf
13 --- we wonder if this is necessary, if medical people
14 could get at the children with hearing problems in infancy.
15 In other words, if we had the proper type of hearing
16 clinics in the Province, then perhaps we wouldn't have
17 so many deaf people, and other people who are handicapped
18 through hearing loss, and, well, I don't know too much
19 about these fields. I assume that the same thing would
20 apply in the field of vision, and that we need some
21 pretty good clinics at that level.

3 jb 22 THE CHAIRMAN: Thank you very much
23 gentlemen, and Dr. Buckwold. I think at this stage
24 you will be free to return home, and perhaps Dr. Baltzan
25 and I will feel a little better that we haven't deprived
26 our hospital of one of its Department Heads any longer.
27 We are very grateful for the assistance which you gentle-
28 men have been to us, and as I said before, this brief
29 will receive careful consideration in due course.

1 jb 30 DR. BUCKWOLD: Thank you very much, Mr.



1 Chairman, and Members of the Commission. We really
2 appreciate this opportunity of staying in Regina a little
3 extra time.

4 I would like to add this before we close
5 something which I didn't say, and that is that we here
6 have been very, very fortunate in the fact that people
7 like Mr. Bates and Mr. Talbot and Mr. Roeher, who are
8 members of government agencies, who are often in conflict
9 at more senior levels, have given all of us a great deal
10 of assistance and co-operation in this work and we have
11 found them involved in trying to co-ordinate the services
12 for the handicapped. Thank you once again for listening
13 to us.

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1 SUBMISSION OF THE CANADIAN OSTEOPATHIC AID SOCIETY

3 APPEARANCES:

4 Mr. L. Ford - Director

5 Mr. Foster M. Froom - Director

7 ----EXHIBIT No. 95: Brief of the Canadian
8 Osteopathic Aid Society

9 ----

10 MR. FORD: Mr. Chairman and Members of
11 the Commission, I judge from your earlier remarks this
12 evening that as laymen and as consumers we shall be probably
13 looked upon with a more pleasant eye by the members of this
14 Commission.

15 We are pleased to have this opportunity to
16 present this brief on behalf of the Canadian Osteopathic
17 Aid Society to the Royal Commission on Health Services for
18 Canada.

19 At the outset we wish to explain that the
20 Canadian Osteopathic Aid Society is a laymen's organization
21 having a Dominion Charter and representing citizens of
22 this province along with those of other provinces who have
23 benefited physically throughout the years from treatments
24 given by Doctors of Osteopathy. The Board of Directors
25 of our organization, consisting of citizens from the
26 various provinces, has laid down plans and policies of
27 operation towards its long range goal which is to make
28 osteopathic health care more readily available to the
29 people of Canada.

30 In the United States there are 13,000 active



1 Doctors of Osteopathy who serve as family doctors for 6%
2 of the United States population. Doctors of Osteopathy
3 are recognized by the United States Federal authorities
4 and 38 states as fully qualified practitioners of all
5 branches of medicine and surgery. Osteopathic Physicians
6 are educated in six Osteopathic colleges in the U.S.A.
7 After high school graduation, a minimum of three years
8 pre-osteopathic education in a recognized liberal arts
9 college or university is required prior to matriculation
10 in Osteopathic Colleges where all fields of medicine and
11 surgery are covered in an intensive four year course of
12 osteopathic education and training which includes:-
13 Anatomy Tropical Medicine Parasitology
14 Embryology Immunology Histology
15 Radiology Physiology Surgery
16 Biochemistry Orthopedic Surgery Toxicology
17 Urology Pharmacology and Otorhinolaryngology
Materia Medica
18 Ophthalmology Sanitation
19 Anesthesiology Bacteriology Osteopathic
20 Theories, practice
and technic.
21 Pathology Public Health Psychiatry
22 Preventive Medicine
23 Internal Medicine Hygiene Therapeutics
Neurology
24 Obstetrics & Pediatrics Therapeutics
Gynaecology
25 Dermatology.

26
27 The faculty of his professional college
28 confer upon him the degree "Doctor of Osteopathy." This
29 does not complete his education. 98% of osteopathic
30 graduates complete an additional year of training in



1 rotating internships in osteopathic hospitals accredited
2 and approved for that training. In the event that the
3 doctor choses to serve in a field of specialty practice
4 he must complete an additional three to five years in
5 residency training in his chosen specialty field. His
6 academic pre-doctorate course consists of four years em-
7 bracing at least forty months of professional training
8 (5,000 hours). His one year of post doctorate internship
9 consists of fifty weeks advanced professional training.

10 Currently, the colleges which provide this
11 training, and the only colleges granting the degree
12 "Doctor of Osteopathy" are located in the United States.
13 Each of them is a constituent member of the American Council
14 on Education, an organization of institutions of higher
15 learning in the United States. Each of these colleges
16 is inspected for accreditation by the American Osteopathic
17 Association and by the Canadian Osteopathic Association
18 annually. Certain of the licensing bodies and boards of
19 examiners in the United States also inspect these colleges.

20 It is also of interest to note that
21 hospitals in the United States accept Osteopathic
22 Physicians on the hospital medical staff whether listed
23 by the American Hospital Association or accredited by the
24 joint commission on Accreditation of Hospitals. Further-
25 more, the United States Federal Government is providing
26 grants to colleges of osteopathy for research and teaching
27 on the same basis as grants are made to other medical
28 colleges training Physicians and Surgeons.

29 It has been estimated that 65 million
30 treatments were given to Americans by Doctors of Osteopathy



1 during 1960 and that approximately 200,000 Canadians -in-
2 cluding people from all walks of life - visit Doctors of
3 Osteopathy annually and that the number is rapidly in-
4 creasing... The osteopathic profession has been serving
5 the people of Canada for more than sixty years. It
6 intends to continue to serve the Canadian people on
7 into the future.

8 The Canadian Osteopathic Aid Society
9 prays that all licensed Doctors of Osteopathy shall have
10 the privilege of co-operating fully and freely in any
11 plan of health service which may evolve to the benefit
12 and improvement of the health care of the people of
13 Canada. Towards this end the attention of the Royal
14 Commission is respectfully directed to the policy of the
15 Canadian Osteopathic Association established in 1945:

16 "WHEREAS the primary objective of the Association is
17 the promotion and improvement of the public health; and
18 WHEREAS it recognizes the fact that certain portions
19 of the population of Canada are unable to maintain
20 themselves in good health; and
21 WHEREAS it recognizes that a healthy people are
22 a happy and economically stable people;
23 IT THEREFORE APPROVES the principle of national
24 health insurance and will endorse any workable
25 plan which will assure complete and adequate health
26 service for all income groups and which at the
27 same time will preserve and protect the rights of
28 the patient to a completely free choice of duly
29 qualified physicians of any legalized school of
30 practice without discrimination."



1 The inclusion of osteopathic care and
2 complete recognition of Osteopathic Physicians in any
3 proposed medical health plan would be consistent with the
4 claim to provide adequate health service to all citizens
5 of Canada.

6 In line with the objectives of the Canadian
7 Osteopathic Aid Society, we now make the request that
8 this Commission, in considering the health needs of the
9 people of Canada, recommend that recognition, rights and
10 privileges under any proposed health plan be given to
11 Doctors of Osteopathy to the same extent as those given
12 to Doctors of Medicine.

13 THE CHAIRMAN: Thank you very much, Mr.
14 Ford. Do you wish to add anything, Mr. Froom?

15 MR. FROOM: No, except an observation
16 that as a laymen organization we feel that it is the
17 right of every citizen to avail himself of all healing
18 arts regardless of his ability to pay, regardless of
19 whether he is white or black, regardless of his religion,
20 and the Osteopathic Aid Society of Canada's main point
21 is to see if we can put within the grasp of every citizen
22 who wants it the right to have osteopathic treatment.
23 That is our main submission.

24 THE CHAIRMAN: Were any representations
25 made to the Government of Saskatchewan in connection
26 with the Act for medical services passed in November?

27 MR. FROOM: Yes, Mr. Chairman, a sub-
28 mission was made to that body.

29 THE CHAIRMAN: Judging from the wording
30 of the Act it was not acceded to?



The inclusion of osteopathic care and

In line with the objectives of the Canada

Osteopathic Association, we now make the request that

this Commission, in considering the bill, please be

people of Canada, understand that osteopathic rights and

privileges under any proposed legislation should be given to

members of the profession to the same extent as those given

to doctors of medicine.

THE CHAIRMAN: Thank you very much, Mr.

Field. Do you wish to add anything, Mr. Brown?

MR. BROWN: No, except a observation

that as a layman organization we feel we have the

right of every citizen to avail himself of all services

and regardless of his ability to pay, regardless of

whether he is white or black, regardless of his religion,

and the Osteopathic and Society of Medicine main point

is to see if we can get within the grasp of every citizen

who wants it the right to have osteopathic treatment.

That is our main submission.

THE CHAIRMAN: Were any representations

made to the Government of Saskatchewan in connection

with the bill for medical services passed in November?

Mission was made to that body.

THE CHAIRMAN: Judging from the wording

of the bill it was not intended to



1 MR. FROOM: No. We gain little by
2 little as time goes by.

3 COMMISSIONER BALTZAN: I have no questions,
4 but I do want to assure you gentlemen of my earnest
5 interest in everything you have to say. There are one
6 or two questions, but I think I would not ask you
7 because it comes more in the category of an osteopathic
8 person himself.

9 MR. FORD: Yes, we appreciate that very
10 much, sir. I believe you might get an opportunity of
11 questioning the Canadian Osteopathic Society when they
12 present their brief later on in the East, but I would
13 like to add that we as layment are very definitely in-
14 terested in this. Maybe it is from a selfish view-
15 point to some extent, but many of us have had personal
16 experiences along this line. One that is very close
17 to home to me is in respect of my wife, if you don't
18 mind my mentioning this personal experience, who in
19 1954 became partly paralyzed down her left side as a
20 result of very severe fainting spells. She went
21 through a number of tests, diagnosis, thinking that she
22 was suffering from a brain tumour. However, as a
23 result of the tests it was found to our pleasure that
24 she did not have this affliction, but at the same time
25 she did have this paralysis, and after several months
26 she was told by medical doctors attending her that she
27 may become completely incapacitated. That was quite
28 a blow to her and the family, and she did not give up,
29 but decided to try an osteopath. As a result over the
30 last five or six years she has been able to carry on her



MR. BROWN: No. We gain little by

COMMISSIONER ALSTON: I have no question

out I do want to assure you that I am not in any way
interested in everything you have to say. There are one
or two questions, but I think I would not ask you
because it comes more in the category of an official
person himself.

MR. BROWN: Yes, we appreciate that very
much, sir. I believe you might get an opportunity to
question the Canadian Government's policy when they
present their paper later on in the week, but I would
like to add that we as taxpayers are very interested in
the matter. It is from a selfish view-
point to some extent, but many of us have had personal
experience along this line. One that is very clear
to me is in respect of a wife, if you don't
mind my mentioning this point of experience, who is
left alone, partly paralyzed now, and left as a
result of very severe rheumatoid arthritis. She wants
enough of a number of visits, disabilities, including loss of
use of her right arm and leg. However, as a
result of this illness it was found to our pleasure that
she did not have any disability, but at the same time
she did have this arthritis, and after several months
she was told by medical doctors attending her that she
may become completely incapacitated. That was quite
a blow to her and the family, and she did not give up,
but decided to try an operation. As a result over the
last five or six years she has been able to carry on her



1 work in the home and the paralysis has practically left
2 her. Our position in Saskatoon where I live is that
3 we have no practising osteopathic physician. There is
4 one who travels there only once a month now, which is
5 entirely inadequate for a population of 90,000, and our
6 problem is that we have advertised in their journals for
7 osteopathic physicians to come and establish a practice
8 in Saskatoon, and other parts of the Dominion, but the
9 legislative climate here and elsewhere is not conducive
10 to them coming here and making full use of their training.

11 THE CHAIRMAN: Thank you very much,
12 Mr. Ford and Mr. Froom. We will give consideration to
13 this brief.

14 MR. FORD: Thank you very much, sir.

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SUBMISSION OF THE MEDICAL SERVICES INCORPORATED

APPEARANCES :

Mr. P. A. Mahon

Dr. J. A. Forrester

Mr. R. R. Sawa

Dr. J. H. MacIntosh

Mr. R. J. Mathers

Mr. H. E. Carrier

-----EXHIBIT No. 96: Submission of Medical Services
Incorporated.

MR. MAHON: Mr. Chairman, I am not appearing as a solicitor this evening, but as the President of Medical Services. Having listened to the hearings of the Commission during the day I am quite aware there is no need for us to read our brief or even the summary. It is quite obvious that the Commission has looked through these briefs, and from the questioning has pretty thoroughly investigated them before coming to the meeting.

The only thing that we like to call attention to particularly are two addendums to the brief which were filed this evening dealing with two new contracts which are being offered by Medical Services which were finally approved for issue by the Executive in the past week.

One is an individual contract for in-

A. Harrison

P. Jones

W. Harrison

J. Harrison

1

---EXHIBIT No. 1: State of Medical Services
Harrison, W. J.

W. J. Harrison: I am not

appearing as a solicitor this morning, but as the

representative of Medical Services, having listened to

the testimony of the Commission and on the day I am quite

convinced that it is not for us to read our brief or even

the summary. It is quite certain that the Commission

has looked through these briefs, and from the questioning

has probably thoroughly investigated them before coming

to the hearing.

The only thing that we like to call

attention to particularly are the amendments to the brief

which were filed on this evening together with two new

contracts which are being offered by Medical Services

which were finally approved for issue by the Executive

in the past week.

There is an individual contact for in



1 hospital services, medical services and this will be
2 available to all citizens of the Province who are over
3 65 or not and this covers the services of the medical
4 practitioners in the hospital. I note on the addendum
5 there is one error inasmuch as it does not cover the
6 fact that it also covers and permits specialist consulta-
7 tion in the hospital.

8 The other is the individual comprehensive
9 contract considerably expanded over the present group
10 contract which we have in Appendix "A" to the numbers it
11 covers. For instance, additional diagnostic procedure
12 service up to the sum of \$200. It does cover one re-
13 fraction per year, periodic health examinations under
14 certain conditions as set out in the addendum and as we
15 do in our present contracts it covers the special nursing
16 and physiotherapy to a limited degree.

17 THE CHAIRMAN: - How far on the special
18 nurses?

19 MR. MAHON: - Up to five days, up to three
20 nurses a day. That has been covered in the ordinary
21 M.S.I. group contract for some years now.

22 I might mention the M.S.I. in addition to
23 falling within the Province of Saskatchewan does cover
24 nursing services under the Railway contracts in the Provinces
25 of Alberta and British Columbia as the plans in those
26 Provinces felt their situation did not permit them to
27 cover nursing services. So, we are not merely a strictly
28 provincial body.

29 We are prepared to supply the Commission
30 with financial statistics of the organization if it is



2 available to all citizens of the Province who are over
3 65 or not and this covers the services of the medical
4 practitioners in the hospital. I note on the schedule
5 fact that it also covers and permits specialist consulta-
6 tion in the hospital.

7 The other is the individual comprehensive
8 contract considerably expanded over the present group
9 contract which we have in Appendix "A" to the numbers 10
11 covers, for instance, additional and special procedures
12 services up to the sum of \$100. It does cover one re-
13 sultion per year, periodic health examinations under
14 certain conditions as set out in the schedule and as we
15 do in our present contracts is never the special nursing
16 and physiotherapy to a limited degree.

17 THE CHAIRMAN: How far on the special
18 Mr. MAHON: Up to five days up to three
19 nurses a day. That has been covered in the ordinary
20 I might mention the M.B.I. in addition to
21 failing within the Province of Saskatchewan does cover
22 nursing services under the Railway contracts in the Provin-
23 of Alberta and British Columbia as the plans in those
24 provinces, fair work situation did not permit them to
25 cover nursing services. So, we are not merely a strictly
26 We are prepared to supply the Commission
27 with financial statistics of the organization if it is



1 desired and Mr. Sawa, our Comptroller has this available
2 for the Commission.

3 We are prepared to answer any questions
4 that you wish to direct to us and if you direct them
5 particularly to me and I cannot answer them then I will
6 send them off to the people who can best answer.

7 THE CHAIRMAN: The brief will be Exhibit
8 No. 96.

9 ---EXHIBIT No. 96: Submission of Medical Services
10 Incorporated.

11
12 THE CHAIRMAN: Mr. Mahon, just to refresh;
13 you cover how many people in Saskatchewan?

14 MR. MAHON: At the present time slightly
15 over 218,000 people but in addition to that we cover the
16 socially indigent people of the Cities of Saskatoon,
17 Prince Alberta, Regina, Moose Jaw, North Battleford and
18 Humboldt under contracts with the Municipal organizations.

19 THE CHAIRMAN: That is administrative?

20 MR. MAHON: Yes, and also the students at
21 the University of Saskatchewan. We do not count those
22 in our 218,000.

23 THE CHAIRMAN: I think that perhaps the
24 most pertinent question, the most vital question we can
25 put to you, Mr. Mahon, and your associates, is what is
26 going to happen to you when the program of the Saskatchewan
27 Government is brought into operation.

28 MR. MAHON: I think possibly the difficulty
29 in answering that question is that I do not think it
30 is going to become operative. If it should - I mean,



4 that you wish to direct to us and if you direct them
5 particularly to me and I cannot answer them then I will
6 send them off to the people who can best answer.

7 THE CHAIRMAN: The matter will be Exhibit
8 No. 96.

9 --EXHIBIT No. 96: Submission of Medical Services
10 Incorporated.

11 THE CHAIRMAN: Mr. Mahon, just to refer
12 you cover how many people in Saskatchewan?

13 At the present time slightly
14 over 20,000 people but in addition when we cover the
15 people of the City of Saskatoon.

16 Mr. Mahon, what is the hospital and
17 hospital's name connected with the hospital organization
18 THE CHAIRMAN: That is Saskatchewan.

19 Mr. Mahon: Yes, and also the students at
20 the University of Saskatchewan. We do not count those
21 in our 20,000.

22 THE CHAIRMAN: I think that perhaps the
23 most pertinent question, the next vital question we can
24 put to you, Mr. Mahon, and your associates, is what is

25 going to happen to you when the program of the Saskatchewan
26 Government is brought in to operation.

27 MR. MAHON: I think possibly the difficulty
28 in answering that question is that I do not think it
29 is going to become operative. If it should - I mean,



1 the Government, I believe, can declare that as of a
2 certain date that it will have this plan in operation
3 but it is my feeling both as a member of this Board and
4 as an individual living in the Province that first they
5 must obtain the co-operation of the medical practitioners
6 in this Province, they must obtain an agreement from the
7 physicians to render services under the terms of the
8 Act. The Act does not preclude ---

9 THE CHAIRMAN: We appreciate that.
10 I think we all understand that fully after what we have
11 heard since Monday morning that there is or seems to be
12 a measure of disagreement between the Government of
13 Saskatchewan and the physicians. Assuming that the
14 plan does go into operation, what becomes of Medical
15 Services Incorporated and the other two voluntary non-
16 profit organizations giving similar service in the insurance
17 medical coverage in Saskatchewan?

18 MR. MAHON: Well, if the Government
19 scheme becomes effective then it is accepted by the
20 profession.

21 THE CHAIRMAN: Let us pass that by and
22 get to the point of accepting on an assumption it will
23 go into operation.

24 MR. MAHON: If it goes into operation
25 Medical Services at the present time would still be
26 available to those people who desire to cover themselves
27 under the terms of the contracts.

28 THE CHAIRMAN: You mean additional to?

29 MR. MAHON: The Government coverage, yes.
30 At the present time our contracts, for instance, do not



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2 certain date that it will have this plan in operation
3 but it is my feeling both as a member of this Board and
4 must obtain the co-operation of the medical practitioners
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23 MR. MAHON: If it goes into operation
24 medical service at the present time would still be
25 available to those people who desire to cover themselves
26 under the terms of the contracts.
27 THE CHAIRMAN: You mean additional for
28 at the present time our contracts, for instance, do not



1 prevent double coverage by subscribers. Many subscribers,
2 we are quite aware, are covered for instance today by
3 insurance companies for medical services in addition
4 to which they are covered by M.S.I. We know this double
5 coverage does exist. There would be no reason why the
6 people who desire to be covered would not be covered by
7 M.S.I. in addition to the Government. Many people quite
8 obviously would be much happier with that coverage.

9 THE CHAIRMAN: Do you seriously hold
10 the view that if there is a compulsory physicians' service
11 program brought into operation in this Province that
12 any substantial number of people will also carry coverage--?

13 MR. MAHON: The question is whether it
14 would be substantial, that is something we have to know
15 for a fact.

16 THE CHAIRMAN: But your own reasoning
17 and judgment of the people of the Province?

18 MR. MAHON: There would be many but I
19 do not believe under those conditions we would maintain
20 a majority of our present membership. No, it would be
21 greatly reduced.

22 THE CHAIRMAN: Let us see what was the
23 situation in the area where there is now full-coverage
24 or in the Swift Current area?

25 MR. MAHON: We have made no attempts to
26 sell in the Swift Current area since the time they have
27 had the plan in operation.

28 THE CHAIRMAN: Why not?

29 MR. MAHON: The doctors in that area were
30 co-operating with the scheme wholeheartedly and, therefore,



1 we did not try to enter that field. We felt it was better
2 to have it there and leave it in full operation.

3 THE CHAIRMAN: Well, it would not have
4 affected the scheme if anybody wanted double coverage,
5 would it?

6 MR. MAHON: No, but we felt it would be
7 wiser to leave it as a pilot scheme completely independent.
8 In addition we also have, as you are aware from Appendix
9 "A", a type of contract which the Government does not
10 propose to cover in its present legislation and that is an
11 extended health benefit contract which covers the services
12 other than they would cover and, therefore, we will still
13 be open for that particular field.

14 THE CHAIRMAN: Nursing services and all
15 those services excluded?

16 MR. MAHON: And drugs and ambulance
17 service and so on.

18 THE CHAIRMAN: In your contract do you
19 propose to insure those who up to very recently, in any
20 event, were not eligible for insurance, that is, those
21 with existing disabilities?

22 MR. MAHON: We have covered, I think there
23 may be some misunderstanding on that particular point
24 but we do cover people with previous disabilities although
25 they are excluded maybe for that particular thing for a
26 period of time. The new contracts, for instance, which
27 we have presented as the addendum cover for pre-existing
28 conditions after nine months.

29 THE CHAIRMAN: You have no contract that
30 covers, that will take in immediately a person suffering

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we have presented as the addendum cover for pre-existing

conditions after nine months.

THE CHAIRMAN: You have no contract that

covers, that will take in immediately a person entering



1 from some disability that has up to now been regarded
2 as not insurable?

3 MR. MAHON: On larger group plans we
4 have done so but not on the individual or small one be-
5 cause of the strict financial and economic repercussions --
6 on the larger groups we have and in the municipal contracts
7 we have.

8 THE CHAIRMAN: Have you made your contracts
9 non-cancellable or non-terminable?

10 MR. MAHON: No, they have not because
11 in order to control abuse which does exist. In certain
12 circumstances it is necessary that you do have some control
13 such as right of cancellation and one of the only measures
14 you have against the individual subscriber who does abuse--

15 THE CHAIRMAN: In any event, you are
16 maintaining the termination clause?

17 MR. MAHON: Yes sir, we very rarely use
18 it but it is there in case of necessity.

19 THE CHAIRMAN: That is at the 30 day
20 termination clause?

21 MR. MAHON: Yes.

22 THE CHAIRMAN: You have given in your
23 submission the statistical operation of the plan?

24 MR. MAHON: The enrollment, yes.

25 THE CHAIRMAN: The enrollment and you
26 cover here the matter of how much is paid to the physicians,
27 that is what your operating cost is?

28 MR. MAHON: We have not given the financial
29 statistical figures as yet but those are available as
30 I mentioned earlier. They were not made part of the



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MR. MAHON: We have not given the financial

statistical figures as yet but those are available as

I mentioned earlier. They were not made part of the



1 presentation because it was going to be public.

2 THE CHAIRMAN: Will you please make them
3 available now?

4 MR. MAHON: They are here, Mr. Sawa has
5 them now.

6 ---EXHIBIT No. 96A: Medical Services Incorporated
7 Financial Statistics, December
8 31, 1960.

9 THE CHAIRMAN: Were any representations
10 made by M.S.I. to government at the time the bill was
11 under consideration for incorporation of the organization?

12 MR. MAHON: Not at that time. We did
13 make representations, we filed a brief and appeared before
GGG/jb 2 14 the Thompson Committee. At the time of the bill there
15 was no opportunity given for any organization, as far
16 as I am aware, to make representations to the Government.

17 THE CHAIRMAN: Do you propose making any?

18 MR. MAHON: It would appear possibly at
19 the present time that in view of the viewpoint of the
20 Government it would be rather useless even to make re-
21 presentations today.

22 THE CHAIRMAN: Well, there is one sure
23 way of not getting any place. Like the fellow that asked
24 the girl to marry him but doesn't propose, he does not
25 get very far.

26 MR. MAHON: That is unless he gets
27 assistance from the Courts.

28 THE CHAIRMAN: The fact is you have not
29 gone forward with any proposition whereby administration
30 organization and experience of such an organization as yours,

it was going to be public.

THE CHAIRMAN: Will you please make them

MR. MAHON: They are here. Mr. Saws has

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---EXHIBIT No. 96A: Medical Services Incorporated
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THE CHAIRMAN: Well, there is one sure

way of not getting any place. Like the fellow that asked

the girl to marry him but doesn't propose, he does not

get very far.

MR. MAHON: That is unless he gets

assurances from the Government.

THE CHAIRMAN: The fact is you have not

gone forward with any proposition whereby administration

organization and experience of such an organization as you



1 which is very considerable, might be salvaged and
2 incorporated into some program?

3 MR. MAHON: May I suggest in the past
4 the Honourable T. C. Douglas, the former Premier of the
5 Province has stated very definitely he would not under any
6 circumstances have anything to do with medical services
7 under the government. He made it very definitely known
8 to us as well as other bodies.

9 THE CHAIRMAN: He appears to have gone
10 to other fields now?

11 MR. MAHON: That is correct.

12 THE CHAIRMAN: You see, it is this element
13 of uncertainty that hangs over an organization such as
14 M.S.I. that leaves a question as to how far this Commission
15 may feel it necessary to go into the operation of M.S.I.,
16 into the details and depth, for instance, that we went
17 into with the Manitoba Medical Services which was an
18 organization in full operation and with every intention
19 of continuing more or less indefinitely. Now, has anyone
20 else anything else to say in this regard?

21 DR. MAC INTOSH: We are doctor sponsored,
22 we have the most cordial relations with the College of
23 Physicians and Surgeons and we anticipate that with
24 their co-operation and by virtue of our co-operation with
25 them that it is likely we will continue in business.
26 As a practising physician in this Province and under the
27 terms of the present Act and as an individual, I am unable
28 to work for this Government, but I am able to co-operate
29 entirely with M.S.I.

30 THE CHAIRMAN: Mr. Carrier, what are your

which is very considerable, might be salvaged and

incorporated into some program.

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As a practicing physician in this Province and under the

terms of the present Act and as an individual, I am unable

to work for this Government, but I am able to co-operate

entirely with M.S.I.



1 views on it? You have been in this organization for
2 practically since its inception, as I recall?

3 MR. CARRIER: I think, sir, we have
4 satisfied the needs of a great number of people in the
5 Province and at the same time have had excellent relations
6 with the College of Physicians and Surgeons. Right from
7 the organization 14 years ago we were then and still are
8 now completely opposed to anything that is compulsory
9 in the field of medicine. At the same time we believe
10 that the expansion of the welfare state is not in the
11 best interest of the public. We recognize that there
12 are certain groups of people in the Province who may need
13 some special help in securing coverage but we do not
14 believe that this is good reason to cause all the people
15 through compulsion to accept medical care when the
16 greatest percentage of them, the largest percentage of
17 them, are able to provide it for themselves on a voluntary
18 basis.

19 THE CHAIRMAN: You see, you are not
20 speaking as a doctor because you are a teacher, you are
21 not in the medical profession.

22 MR. CARRIER: That is so. I greatly
23 deplore the chaotic condition that exists in Saskatchewan
24 not among the doctors only but it certainly does exist,
25 but among the people who require the services of those
26 doctors. I am one of those and I am very greatly con-
27 cerned right up to the moment as to what has happened
28 in the medical profession and if it is any indication
29 of what is going to happen in the future then we have
30 reason to be downright alarmed.



MR. GARRNER: I think, sir, we have

with the College of Physicians and Surgeons. Right from
the organization 14 years ago we were faced with and still are
now completely opposed to anything that is compulsory

throughout the country to accept medical care when the
percentage percentage of them, the largest percentage of
them, say to provide it for themselves on a voluntary

THE CHAIRMAN: You see, you are not
speaking as a doctor because you are a teacher, you are
not in the medical profession.

MR. GARRNER: That is so. I guess
therefore the obvious condition that exists in Washington
and among the doctors only, but in certain cases exist,
and among the people who receive the services of these
doctors. I am one of these and I am very greatly con-
cerned right up to the moment as to what has happened
in the medical profession and if it is any indication
of what is going to happen in the future when we have



jb 1

1 MR. MAHON: It is not because I represent
2 here continued medical service only, because there are
3 other voluntary agencies I am just as enthusiastic about.
4 I would like to see them continued, and I would like to
5 see the people who are able to pay for their own services
6 voluntarily allowed to do so. I would like to see help
7 given to those who need help, and I would like to see the
8 doctors free to practice medicine of the very highest
9 quality, that they wish to do, and can do if they are
10 allowed to do.

11 THE CHAIRMAN: Now, there is a matter
12 that makes a difference say between Saskatchewan and
13 Manitoba. We find in this Province three organizations
14 similar in scope to Medical Services Incorporated,
15 Group Medical, and the Medical Co-op, that is not its
16 official name I know, but you know the organization that
17 I am referring to. How does it come about that in this
18 Province that there would be three groups catering to
19 the same service and servicing the same needs?

20 DR. FORRESTER: Because they were started
21 historically at different times, and one group developed
22 and serviced one area. Another group developed spontaneously
23 in another area, and they haven't amalgamated because of
24 certain different principles.

25 THE CHAIRMAN: What are those differences?

26 DR. FORRESTER: Well, the Medical Co-op
27 started in Saskatoon and based its principles on a rather,
28 what eventually proved to be a rather arrogant attitude
29 between the plan's directors and the medical profession.

30 THE CHAIRMAN: Well, that was a matter of



1 MR. MAYON: It is not because I responded
2 here continued medical service only, because there are
3 other voluntary agencies I am just as comfortable about.
4 I would like to see them continued, and I would like to
5 see the people who are able to pay for their own services
6 voluntarily allowed to do so. I would like to see help
7 given to those who need help, and I would like to see the
8 doctors free to practice medicine of the very highest
9 quality, that they wish to do, and can do if they are
10 allowed to do.

11 THE CHAIRMAN: Now, there is a matter
12 that makes a difference say between Saskatchewan and
13 Manitoba. We find in this Province there are organizations
14 similar in scope to Medical Services Incorporated,
15 Group Medical, and the Medical Corp., that is not its
16 official name I know, but you know the organization that
17 I am referring to. Now does it come about that in this
18 Province that there would be three groups catering to
19 the same service and involving the same needs?

20 MR. MAYON: Because they were started
21 historically at different times, and one group developed
22 and evolved one area. Another group developed elsewhere
23 in another area, and they haven't aligned because of
24 certain different circumstances.

25 MR. FORESTER: Well, the Medical Corp.
26 started in Saskatoon and based its principles on a rather
27 what eventually proved to be a rather arrogant attitude
28 between the plan's directors and the medical profession.
29 THE CHAIRMAN: Well, there was a time when



1 personality and policy?

2 DR. FORRESTER: It was enough to convince
3 the profession that they had to institute a plan on their
4 own in that particular area, which they did, and that
5 led to the inception of M.S.I. In Regina, as you will
6 hear tomorrow, Group Medical Services developed from a
7 similar type of organization, but expanded and grew on
8 a different set of principles. Basically the only thing
9 that has kept Group Medical Services and M.S.I. from
10 amalgamating has been two things. One is that Group
11 Medical confine their experience to large groups, relatively
12 large groups, whereas M.S.I. branched out very quickly
13 into the field of individual coverage, and it was one
14 of the first plans in North America to do this, and it
15 has tremendous experience in this field. By other
16 circumstances, Group Medical Service has a lot of sub-
17 scriber representation in terms of voting privileges and
18 so on, which manifests this theoretically in the operations
19 of the plan. In actual fact, I don't think it makes
20 very much difference. M.S.I. is set up differently,
21 as you will have noticed from reading the Constitution,
22 Bylaws, and Regulations, but this has kept the two plans
23 from amalgamating, because our experience with individuals
24 has led us into different lines of thought, and through
25 experience with groups, has kept them a rather compact
26 unit, but we are both doing the same kind of service,
27 and I think the competition which we have provided between
28 the two plans has been very good.

29 THE CHAIRMAN: There has been doubled
30 administration costs?



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THE CHAIRMAN: There has been doubt

administration costs?



1 DR. FORRESTER: Maybe half of it, but I
2 don't think really ---

3 THE CHAIRMAN: Well, some increase?

4 DR. FORRESTER: The administration costs
5 in this type of group are less than when dealing with the
6 type of plan we have.

7 THE CHAIRMAN: You see, it has this re-
8 sult, that in Manitoba the Government came forward with
9 a plan to cover medical services, and proposed using
10 Manitoba medical as the vehicle to administer its plan,
11 and that was easy there, because there was only the one
12 plan, one organization, in operation, which covered the
13 whole Province

14 DR. FORRESTER: Mr. Chairman, you are not
15 naive enough to think that the Government of this Province
16 couldn't surmount the difficulty of amalgamating the
17 plans, if they wished to do so.

18 THE CHAIRMAN: Don't make any assumption
19 about just how naive I might be.

20 DR. FORRESTER: We have approached them
21 ourselves often for co-operation, and we have never had
22 a whittle.

23 THE CHAIRMAN: If you are trying to say
24 a little dramatically that you don't expect that you might
25 be employed by the Government, but you might keep my
26 perspicacity and so forth out of the discussion.

27 MR. MAHON: There has been, over a period
28 of years, discussion as to the desirability of amalgamating
29 the two plans. The difficulty of the Co-op, of course,
30 is the principle of the Co-op. The losses, if any, under



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sult, that in Montreal the Government came forward with
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Montreal medical as the vehicle to administer the plan,
and that was easy there, because there was only the one
plan, one organization, in operation, which covered the

MR. FORRESTER: Mr. Chairman, you are re-
lative enough to think that the Government of this Province
couldn't surmount the difficulty of establishing the
plans, if they wished to do so.

THE CHAIRMAN: Don't take any exception
about just how alive I might be.
MR. FORRESTER: We have experienced them
survives often for co-operation and we have never had
a vehicle.

THE CHAIRMAN: If you are trying to say
a little dramatically that you don't expect that you will
be employed by the Government, but you must keep at
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MR. MASON: There has been, over a period
of years, discussion as to the desirability of separating
the two plans. The difficulty of the Co-op, of course,
is the principle of the Co-op. The losses, if any, under



1 the Co-op plan are payable by the subscribers, whereas
2 under the Medical Services and under G.M.S., any loss
3 under windup, or any period, would be covered by the
4 doctors having to accept a pro-rated return. That a
5 difference makes it very difficult to obtain amalgamation.

6 THE CHAIRMAN: How many people does
7 Medical Co-op cover?

8 MR. MAHON: I must admit that I myself
9 have no figures.

10 MR. SAWA: I would estimate about 4,000.

11 THE CHAIRMAN: So they play a small part
12 in the over-all picture, and it is really the two groups.

13 MR. MAHON: I wish to call to your
14 attention that some years ago there was another medical
15 co-op group at Melfort, which had members across northern
16 Saskatchewan, and ran into considerable financial dif-
17 ficulty, and M.S.I. took over their membership, so that
18 they wouldn't be left without medical coverage. That
19 was during the early period, when I joined the Board
20 myself.

21 THE CHAIRMAN: Mr. Mahon said that even
22 if they are not able to operate in the field of physician
23 services, that there are other areas in which they may
24 insure, nursing costs would perhaps be the largest item?

25 MR. MAHON: Yes, and drugs.

26 MR. HALL: While you are discussing that,
27 I wonder if I might ask Mr. Mahon a few questions on the
28 extended health plan?

29 THE CHAIRMAN: Yes.

30 MR. HALL: On page 20 of the submission,



one Co-op plan are paying by one hundred percent, whereas
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THE CHAIRMAN: How many people does

Medical Co-op covers?

MR. MAHON: I must admit that I myself

have no figures.

MR. SAWA: I would estimate about 8,000.

THE CHAIRMAN: So they play a small part

in the over-all picture, and it is really the two groups

MR. MAHON: I wish to call to your

attention that some years ago there was another medical

co-op group at Melfort, which had members across northern

Saskatchewan, and ran into considerable financial dif-

ficulty, and M.S.I. took over their membership, so that

they wouldn't be left without medical coverage. That

was during the early period, when I joined the Board

myself

THE CHAIRMAN: Mr. Mahon said that even

if they are not able to operate in the field of physician

services, that there are other areas in which they may

insure, bearing costs would perhaps be the largest item?

MR. MAHON: Yes, and drugs.

MR. HALL: While you are discussing that

I wonder if I might ask Mr. Mahon a few questions on the

extended health plan?

THE CHAIRMAN: Yes.

MR. HALL: On page 20 of the submission,



1 Mr. Mahon, as I read it, the extended health plan---

2 MR. MAHON: At the present time, we
3 are just inaugurating this particular type of coverage,
4 and it is our experience and the experience of plans
5 throughout Canada and the United States that have this
6 particular contract that you must have the group basis,
7 at least until you gain sufficient experience of rating
8 and so on. We hope eventually we may be able to offer
9 it to individuals.

10 MR. HALL: But at the present time it is
11 only on the group basis?

12 MR. MAHON: That is correct.

13 MR. HALL: As I understand, page 20
14 further, the extended health benefits are only available
15 to subscribers of your standard service?

16 MR. MAHON: At the present time they are
17 available to those who hold basic medical coverage under
18 M.S.I., or any other trans-Canada medical plan, approved
19 plan such as for instance G.M.S. groups could get ex-
20 tended health benefits from it.

21 MR. HALL: So this service is really an
22 extension available only to those people who hold the
23 other type of coverage?

24 MR. MAHON: As I say, at the present time
25 we do not yet have to consider, for instance the Govern-
26 ment plan.

27 MR. HALL: But this is not at the
28 present alternative?

29 MR. MAHON: No, it is additional.

30 MR. HALL: Have you made any study of the



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MR. MAHON: No, it is additional.

MR. HALL: Have you made any study of the



1 estimated cost of supplying the drugs and medicines
2 referred to in the extended health plan?

3 MR. MAHON: Yes, we have. We sent two
4 members of our organization to visit Quebec Hospital
5 Services in the Province of Quebec, which operates an
6 extended health benefit contract. We also sent them to
7 Oregon and California. Mr. Carrier, who is here, was
8 one of the members of that delegation who went down to
9 investigate this type of contract, and estimations were
10 made at that time, and presented to the Board, and it
11 was on the basis of that recommendation, and Mr. Byron
12 Straight, an actuary from Vancouver, that our rates
13 were based.

14 MR. HALL: Would you be in a position
15 to make those estimates available to our Research Staff?

16 MR. MAHON: Yes.

17 MR. HALL: And am I correct in assuming
18 that you made similar estimates for the other nine items
19 covered?

20 MR. MAHON: Yes, we did.

21 MR. HALL: Could you make them available
22 also?

23 MR. MAHON: Yes.

24 MR. HALL: Did you give consideration to
25 a deterrent fee for the drugs?

26 MR. MAHON: You will notice there is a
27 deterrent in the contract. Over \$80.00 we pay 50%
28 of that, and up to \$100. and over that 80%, to the family
29 group.

30 MR. HALL: The only reason I ask this is



estimated cost of supplying the drugs and medicines referred to in the extended health plan? MR. MAHON: Yes, we have. We sent two members of our organization to visit Quebec Hospital Services in the Province of Quebec, which operates an extended health benefit contract. We also sent them to Oregon and California. Mr. Carrier, who is here, was one of the members of that delegation who went down to investigate this type of contract, and estimations were made at that time, and presented to the Board, and it was on the basis of that recommendation, and Mr. Hyman Straight, an attorney from Vancouver, that our rates were based.

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MR. HALL: Did you give consideration to a deferment fee for the drugs?

MR. MAHON: You will notice there is a deferment in the contract. Over \$80.00 we pay 50% of that, and up to \$100. and over that 60%, to the limit of that. The only reason I ask this



1 so that the Commission can assess the value of the plan.
2 Was this extended health plan in any way motivated by the
3 fact that the Government had proposed a compulsory plan?

4 MR. MAHON: No, I would say not. It was
5 merely an extension. We have always attempted, in Medical
6 Services, to keep our contracts and the available benefits
7 up to the highest level, and to extend them as we saw
8 was possible to do so, and as we hoped to continue to do
9 so.

10 DR. FORRESTER: I would like to apologize
11 to you, Mr. Chairman.

12 THE CHAIRMAN: You don't have to apologize.

13 MR. FORRESTER: For being so out spoken.

14 THE CHAIRMAN: Being out spoken is never
15 a quality to apologize for, but whether it indicates an
16 attitude on your behalf that, as a group, you have a chip
17 on your shoulder, and maybe you haven't explored all the
18 avenues of co-operation---

19 DR. FORRESTER: In 1958 we submitted a
20 brief to the Provincial Government, asking them to release
21 us from one of the terms of the Health Service Act, which
22 prevented us from entering into contracts with municipal
23 groups, because this limitation was placed at a maximum
24 of \$50.00 per family, and at that time it didn't leave a
25 realistic approach to the cost of health care, which was
26 running around \$18.00 per capita. This brief was turned
27 down. The brief, had the terms been even temporarily
28 listed, would have enabled us to carry our contracts into
29 many communities, and extended our coverage extensively.
30 If your Commission is interested in this brief, it is



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 11 to you, Mr. Chairman.
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 13 MR. FORRESTER: For being so late.
 14 THE CHAIRMAN: Being so late is not
 15 a quality to apologize for, but whether it indicates an
 16 attitude on your behalf that as a group, you have a right
 17 on your shoulder, and maybe you haven't explored all the
 18 avenues of co-operation---

19 MR. FORRESTER: In 1955 we submitted a
 20 brief to the Provincial Government, asking them to release
 21 us from one of the terms of the Health Services Act, which
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 24 of \$50.00 per family, and at that time it didn't leave a
 25 realistic approach to the cost of health care, which was
 26 down. The brief had the terms been even temporarily



1 available also.

2 THE CHAIRMAN: We are interested in all
3 relevant information.

4 MR. MAHON: This particular factor applied
5 to the subsidization by the municipality, through doctors,
6 of the contract. It didn't apply to the contract without
7 subsidization, which we have sold many of, and as a matter
8 of record, some municipalities have ignored this re-
9 striction in the Health Services Act, and we have quite
10 a few municipalities who do subsidize, and they have
11 contracts with us, and the Government is quite aware of
12 this, but up till now at least has not taken any action
13 against them.

14 THE CHAIRMAN: Well, gentlemen, we are
15 grateful to you for having come here, and I just mentioned
16 what was the matter that was of concern, because we have
17 to face reality. There is an Act on the statute books.
18 It appears to be within the legislative powers of the
19 Province, and the Government representative, the Minister,
20 when he was here on Monday said he was proceeding with it,
21 and that is why the question was put as to what your
22 future will be, maybe, when the Act comes into operation,
23 and I think you must appreciate that we couldn't ignore
24 the situation.

25 MR. MAHON: We are very conscious of
26 it ourselves.

27 THE CHAIRMAN: And that is why it was
28 put as pretty well the first question to you, for some
29 rational discussion of the thing, and your eventual answer
30 that you have a field in which to operate, even if the



available also.

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that you have a field in which to operate, even if the



1 Act goes into operation, gives us the situation where there
2 is reason to believe that you will take the time to con-
3 sider your brief carefully, your submissions, and just
4 see where such an organization as yours may fit into a
5 program which may be expected to be repeated in other
6 provinces where there will be a compulsory, or there might
7 be a compulsory, comprehensive medical service plan.

8 MR. MAHON: No doubt sir, the Commission
9 is well aware of the fact. In the last few years there
10 has been quite a growth of voluntary medical plans in
11 Great Britain, despite the British medical scheme, which
12 gives us some heart too.

13 THE CHAIRMAN: There are essential
14 differences, of course, in the Act. There is no
15 provision for contracting out here, and this kind of
16 thing.

17 MR. MAHON: Yes.

18 MR. SAWA: In considering this Act, of which
19 I have a copy, Section 43 almost precludes any physician
20 seeking repayment for services under this Act.

21 THE CHAIRMAN: Well, that is the one where
22 it says if he accepts a payment from the Commission set
23 up under the Act he must accept it as payment in full?

24 MR. SAWA: No sir.

25 THE CHAIRMAN: Well, there is another
26 section to that effect?

27 MR. SAWA: Yes, I quite agree, but Section
28 43 of this provides the payment of a fine of not less
29 than \$5.00 or more than \$50.00, and for a subsequent
30 offence for a fine of not less than \$25.00 nor more than



3 is reason to believe that you will take the time to con-
 4 see where such an organization as yours may fit into a
 5 program which may be expected to be repeated in other
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 24 section to that effect?
 25 MR. SAWA: Yes, I quite agree, but Section
 26 43 of this provides the payment of a fine of not less
 27 than \$5.00 or more than \$50.00, and for a subsequent
 28



1 \$300.00 for failing to submit a report or form, or
2 return, prescribed or required for the purposes of this
3 Act.

4 THE CHAIRMAN: Well, I mean, it just
5 means that if it is the law of the Province, that every-
6 body will be expected to obey it, or suffer the sanctions
7 for disobedience.

8 Thank you again gentlemen, and what you
9 have said will be remembered and taken under advisement.

10 THE SECRETARY: The report that I was
11 given, Medical Services Incorporated, Utilization and
12 Finance Statistics, as at December 31st, 1961, will be
13 Exhibit number 96A.

14

15 ---EXHIBIT No. 96A: Report entitled Medical
16 Services Incorporated.
17 Utilization and Finance
Statics as at December
31st, 1961.

18 MR. MAHON: We wish to thank the
19 Commission for their courtesy here.

20 THE CHAIRMAN: Thank you Mr. Mahon.
21 We will now adjourn until 9:00 o'clock tomorrow morning.

22

23 ---ADJOURNED.

24

25

26

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